

CHAPTER 4

HEALTH RECORDS AND FORMS

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CHAPTER 4. HEALTH RECORDS AND FORMS

Section A - Health Records.

1. Purpose and Background.

- a. The health record is the chronological medical and dental record of an individual while a member of the Coast Guard or the Coast Guard Reserve. The primary reasons for compiling a health record are listed below.
 - (1) To develop an accurate clinical history that will help in future diagnosis and treatment.
 - (2) To protect the Government, the individual concerned, and the individual's dependents. It may be used in adjudicating veterans claims by making permanently available in a single record all entries relative to physical examinations, medical and dental history, preliminary to entry and throughout the individual's entire Coast Guard career. This is accomplished by opening or maintaining medical and dental records:
 - (a) upon entry into the Service;
 - (b) as required to maintain concise, yet complete, records during period of service; and
 - (c) at time of separation.
 - (3) To facilitate appraisal of the physical fitness or eligibility for benefits by making selected, necessary information contained in the health record available to Coast Guard selection boards, disability evaluation system, Board of Correction of Military Records, for income tax purposes, and for claims to the Department of Veterans Affairs.
 - (4) To furnish a basis for collecting statistical information.
 - (5) To identify deceased persons through dental records when other means are inadequate.
 - (6) **To facilitate communication among health care providers, utilization managers, quality assurance and medical records personnel.**
- b. As an individual's service career progresses, the health record increases in value to the Government, the individual, and the individual's family and dependents. Accuracy, therefore, is of the utmost importance in making entries, including entries regarding minor ailments or injuries which appear trivial at the time, but which must be recorded to protect the Government and the individual.

2. Contents of the Health Record.

- a. Each member's health record shall consist of CG-3443 (Health Record Cover) with medical records and dental records arranged as follows:
 - (1) **SECTION I - HISTORY OF CARE.** All forms in this Section shall be arranged in the following order, (a) being the top and (g) being the bottom. Additionally, the forms should be grouped by date with the most recent on top. Do not separate corresponding forms DD-2808 and DD-2807-1.

- (a) Adult Preventive and Chronic Care Flowsheet Form DD 2766
 - (b) Consultation Sheet SF-513
 - (c) Narrative Summary Clinical Resume * SF-502
 - (d) Report of Medical Examination DD-2808 (Rev. Jan 03), and Report of Medical History DD2807-1 (Rev. Jul 01)
 - (e) History and Report of OMSEP Examination Form CG-5447 (Rev.03/03), and Periodic History and Report of OMSEP Examination CG-Form 5447A (03/03)
 - (f) Report on or Continuation of *, ** SF-507
 - (g) Medical Board Report Cover Sheet * NAVMED 6100/1
- (2) SECTION II - RECORDS OF CARE. All forms in this Section (and their civilian equivalents) shall be arranged in the following order, (a) being the top and (b) being the bottom. Additionally, the forms should be grouped by date with the most recent on top.
- (a) Chronological Record of Care SF-600
 - (b) Emergency Care and Treatment SF-558
- (3) SECTION III - RADIOLOGICAL REPORTS. All forms in this Section (and their civilian equivalents) shall be arranged in the following order, (a) being the top (b) being the bottom. Additionally, the forms should be grouped by date with the most recent on top.
- (a) Radiographic Consultation Request/Report SF-519A
 - (b) Medical Record-Radiographic Reports SF-519
- (4) SECTION IV - LABORATORY REPORTS AND ECG REPORTS. All forms in this Section (and their civilian equivalents) shall be arranged in the following order, (a) being the top (b) being the bottom. Additionally, the forms should be grouped by date with the most recent on top.
- (a) Clinical Record - Laboratory Reports SF-514
 - (b) Clinical Record - Electrocardiographic Record SF-520
- (5) SECTION V - MISCELLANEOUS. All forms in this Section shall be arranged in the following bottom (a) to top (i) sequence.
- (a) Chronological Record of Service CG-4057
 - (b) Special Duty Medical Abstract * NAVMED 6150/2
 - (c) Record of Occupational Exposure to Ionizing Radiation * DD-1141
 - (d) Occupational Health Surveillance Questionnaire * CG-5197
 - (e) Syphilis Record * SF-602

- (f) Request for Administration of Anesthesia and for Performance of Operations and other Procedures * SF-522
 - (g) Hearing Conservation Program microprocessor test result strips taped or stapled to the SF-514 Clinical Record-Laboratory Reports form. DD-2215 Reference Audiogram, and DD-2216 Hearing Conservation Data Sheet, will also be placed in section V, in sequential order under the SF 514 "Hearing Conservation Program" form.
 - (h) Eyewear Prescription DD-771
 - (i) Immunization Record SF-601
 - (j) **Authorization for Disclosure DD-2870**
 - (k) **Request for Restriction of Information DD-2871**
- (6) SECTION VI - DENTAL RECORD AND INTERNATIONAL VACCINATION RECORD. All forms in this Section shall be arranged in the following bottom (a), to top (b) sequence.
- (a) International Certificate of Vaccination PHS-731
 - (b) U.S. Coast Guard Dental Record CG-3443-2
 - 1 Sensitivity Sticker * PHS-2410
 - 2 Dental Health Questionnaire CG-5605
 - 3 Health Record - Dental -- (Continuation) * SF-603A
 - 4 Health Record - Dental SF-603
 - 5 NAVMED 6660 Periodontal Chart
 - 6 SF-522 Request for Anesthesia

Note:

* --- When required

** -- SF-507's are attached to and filed after the form they continue

*** - Optional Form

- b. File forms of the same number in their assigned sequence, with the most recent on top of each previous form, e.g., SF-600 dated 94/02/15 is filed on top of SF-600 dated 94/02/14.
- c. Record all dates on the Health Record Cover in the following sequence (all numerals): year/month/day (e.g., 51/02/07).
- d. Reports, including laboratory, X-ray, and consultations, shall be reviewed and initialed by the responsible MO, DO, PA/PYA or NP before they are filed in the health record.
- e. The health record is a legal document. As such, legibility of all information is essential. Patient ID information shall be typed, printed, or stamped. All entries

shall be neat and legible. All signatures shall be accompanied by the stamped or typed name and rank of the practitioner.

3. Opening Health Records.

a. General.

- (1) A health record will be opened at the recruiting office for each individual upon entry into the Coast Guard.
- (2) A new health record will be opened upon reenlistment of personnel with prior USCG service when such enlistment is not effected the day following discharge. In all cases, request the individual's health record covering prior military service from the National Personnel Records Center, St. Louis, MO.
- (3) Other Specific Occasions for Opening Health Record.

<u>OCCASSION</u>	<u>OPENED BY</u>
Officer appointed from civilian	First duty station
Reserve Officer	Unit where procured
Cadet	Academy
Retired Personnel recalled to Active Duty	First duty station
Original Record Lost or Destroyed	Responsible Custodian

4. Terminating Health Records.

a. General Instructions.

- (1) Upon discharge without immediate reenlistment or enlistment in the Coast Guard Reserve, or retirement, forward the health record (Medical Personnel Data Record or MED PDR) to the servicing PERSRU within 2 days of the member's separation. **DO NOT GIVE THE ORIGINAL HEALTH RECORD TO THE MEMBER UPON FINAL SEPARATION.** The member is entitled to a copy of the original health record. Cite the reason for separation on the reverse side of Chronological Record of Service (form CG-4057). The servicing PERSRU/SPO shall forward the health record, placed in a sealed envelope labeled "Sensitive Medical Information – Confidential," along with the PERSRU PDR, to Commander, CGPC (adm-3). (See Section 4-B-27 for additional requirements for form CG-4057.) Health record documents are not filed in the HQ PDR. They will be returned to the unit if received by Commander, CGPC (adm-3) in error. This procedure also applies to the discharge and retirement of a reservist.
- (2) Discharge for immediate reenlistment at the same unit, revocation of appointment as a temporary officer to continue on active duty in permanent status, or retirement with continuation of active duty are not termination of service.

- (3) When a health record is terminated and the dental record is not available for inclusion therein, forward a letter of explanation with the health record.
- b. Release from active duty (RELAD) with concurrent transfer to the Coast Guard Reserve or discharge from active duty with immediate enlistment in the Coast Guard Reserve. Upon RELAD, forward the health record (MED PDR) to the servicing PERSRU within 2 days of the member's separation. The servicing PERSRU shall forward the health record, along with the PERSRU PDR, to District (rs) in which the member will reside after separation.
- c. Disappearance, Other Than Desertion. Whenever an individual disappears and the facts regarding such disappearance are insufficient to justify a conclusion of death, enter a complete account of the circumstances on an SF-600 in the health record. Do not terminate the health record until final disposition.
- d. Desertion.
- (1) When an individual is officially declared a deserter, enter an explanatory note on SF-600. Forward the health record (MED PDR) to the servicing PERSRU within 2 days of determination of deserter. The servicing PERSRU shall forward the health record, along with the PERSRU PDR, to Commander (CGPC) or Commander (CGPC-rpm) for Reservists.
- (2) Upon return of a deserter to his/her own command, a physical examination shall be performed and recorded on the DD-2808. Retain the original for incorporation into the health record, and forward a copy to Commander (CGPC) or Commander (CGPC-rpm) for Reservists with a request for the deserter's health record.
- e. Discharge of Personnel Convicted by Civilian Authorities. When the Commandant directs the discharge of personnel convicted by civilian authorities, the commanding officer will make arrangements for their physical examination, to be recorded on an DD-2808. In the event no medical officer is available, obtain a statement signed by the warden of the penitentiary or reformatory that the person to be discharged from the Coast Guard is physically and mentally qualified for discharge and is not in need of hospitalization. The warden's statement, accompanied by the terminated health record, will be forwarded with the closed out service record.
- f. Discharge of Courts-Martial Prisoners Confined in Federal Penitentiaries, Reformatories, and the Naval Disciplinary Command. When the Commandant directs the discharge of a courts-martial prisoner confined in a Federal penitentiary, reformatory, or the Naval Disciplinary Command, the command to which the prisoner has been administratively assigned shall arrange with the warden for physical examination of the prisoner. Results of this physical examination will be entered on the DD-2808 and signed by the medical officer of the designated penal institution. The command to which the prisoner has been administratively assigned will terminate the health record, using the information furnished on the DD-2808 and the account of medical, dental, and first aid treatments supplied by the penal institution. The terminated health record, DD-2808, and the resume will then be forwarded with the closed out service record.

- g. Retired Personnel (Includes Temporary Retirement). Upon notification of retirement, make an entry on CG-4057 under "Remarks" indicating place, date, and category under which retired. The command having custody of the health record will sign the CG-4057 and forward it to the command having administrative control of the member for inclusion in the closed out service record.
 - h. Cadets. When a cadet's service is terminated, the health record will be terminated and forwarded to the Cadet Record Office, for processing. Following this procedure, the record will be forwarded to the Registrar's Office and held until the departing cadet's class graduates. When this occurs, the record will be forwarded to the Federal Personnel Records Center, St. Louis, MO. This includes cadets who graduate from the Academy but do not accept or are not tendered a commission.
 - i. Officers (Reserve) to Inactive Duty and Officers (Regular) who Resign to Accept a Reserve Commission. In the case of reserve officers being released to inactive duty and regular officers who resign and accept a commission in the reserve, the health record will be terminated.
 - j. Death. Upon notification of death, make an entry on CG-4057 under "Remarks" indicating place, time, date, and a short explanation of the circumstances surrounding death. A commissioned officer will sign the CG-4057 and then deliver it and the terminated health record to the commanding officer (no later than the day following death) for inclusion in and transmittal with the member's service record to Commander (CGPC) or Commander(CGPC-rpm).
5. Custody of Health Records.
- a. General Responsibilities.
 - (1) Health records are the property of the Federal government and must be handled in accordance with the provisions of the **HIPAA Regulations**, the Privacy Act of 1974 and the Freedom of Information Act. Guidance in this area is contained in the Coast Guard Freedom of Information and Privacy Acts Manual, COMDTINST M5260.3 (series). Health record custody, **privacy**, **confidentiality** and security requirements are applicable to all documents **and electronic files** that contain **protected** health information, whether or not filed in the health record, such as Inpatient Medical Records and mental health treatment records. Disposal of all health record documents shall be in accordance with Coast Guard Paperwork Management Manual, COMDTINST M5212.12(series).
 - (a) Since health records contain personal information of an extremely critical or sensitive nature, they are considered class III records requiring maximum security (high security locked cabinets or areas).
 - (b) Except as contained in **HIPAA and** The Coast Guard Freedom of Information and Privacy Acts Manual, COMDTINST M5260.3 (series) the information contained in health records shall not be disclosed by any means of communication to any person, or to any agency unless requested in writing by or with the prior **written authorization** of the

authorization of the individual to whom the record pertains. It is the requestor's responsibility to obtain the **written authorization**.

- (2) Health records shall be retained in the custody of the Chief, Health Services Division of the unit to which the individual is attached. At units where there is no medical officer attached, the health record will become the responsibility of the executive officer in accordance with Coast Guard Regulations, COMDTINST M5000.3(series), who may delegate custody to the senior health services department representative. At units without a health services technician the custody of the health record is the responsibility of the unit's executive officer. Maintenance of these health records may be delegated to health services personnel of another unit (e.g., groups, support centers, etc.). At no time shall individual members keep or maintain their own health record. If there is a need to check out a health record for an appointment at another health care facility, the health record custodian shall have the member complete and sign the health record receipt form (NAVMED 6150/7). The health record custodian shall place the record in an envelope, hand it to the member, and tell the member to return the record as soon as possible following the appointment. The envelope used for record transportation shall bear a printed request reminding outside providers to treat the contents as confidential, and requesting providers to include copies of their consultations or case notes for placement in the health record. The responsibilities contained herein are also applicable to Reserve components.
- (3) Individuals may examine their own health record in the presence of a health services department representative, providing:
 - (a) such examination does not interrupt the unit's scheduled mission, and
 - (b) there is no information contained therein that would be detrimental to the individual's mental well-being, as determined by the member's attending physician.
- (4) **The protected health information necessary for fitness-for-duty determinations, status for deployment and special operational duty, separations from duty, convalescent leave recommendations, inpatient admission and casualty notifications, and other routine disclosures for the military mission, is** subject to inspection by the commanding officer, **their delegate designated in writing**, duly appointed counsel in the case of formal hearings, or duly appointed Coast Guard officials who are conducting authorized investigations. Such inspections will be conducted in the presence of a health services department representative to aid in the interpretation of health information.
- (5) Health services personnel making entries in health records shall ensure all entries, including signatures, are neat and legible. Signature information shall include the stamped or printed name and grade or rate of the signer. Facsimile signature stamps may only be used on the PHS-731 and the SF-601.
- (6) If an erroneous entry is made in a health record, the author of the entry shall draw a diagonal line through the complete entry, make an additional entry

showing wherein and to what extent the original entry is in error, and initial clearly next to the correction.

- (7) Health services personnel are responsible for the completeness of the entries made on any medical or dental form while the health record is in their custody. No sheet shall be removed from the health record except under conditions specified in this Manual.
- (8) Members are not authorized to write in, alter, remove documents from, or otherwise change their health record or its contents. Request for changes to health record contents shall be made **in writing** in accordance with procedures contained **in the HIPAA Privacy Regulation and** in Chapter 16 of the Coast Guard Freedom of Information and Privacy Acts Manual, COMDTINST M5260.3.

6. Transfer of Health Records.

- a. When active duty or reserve personnel are transferred, The Chief Health Services Division, his designee, the Executive Officer, or the senior Health Services department representative will make the necessary entries in the health record and ensure that the current health record, dental record (SF-603) and Certificate of Vaccination (PHS-731), if applicable, are properly completed.
- b. A DD-877 shall be initiated for each record transferred. The DD877 shall be attached to the front cover of the record. The health record will be forwarded to the Coast Guard clinic or Independent Duty Health Services Technician servicing the gaining unit. **Send records using a service that provides a tracking number, such as Priority Mail, Delivery Confirmation, Certified Mail, Insured Mail, or FedEx/Express Mail if time is critical.** (See Article 4-D-7.c. of this Manual for policy regarding transfer of Clinical Records of dependents.)
- c. Transfer to Federal Penitentiaries, Reformatories, or the Naval Disciplinary Command. A letter of transmittal and a copy of the health record shall accompany a member who is being transferred under sentence of a courts-martial (who has not been or will not be discharged immediately) to a penal institution for execution of the unexpired sentence. The original health record, with a letter of transmittal stating the name of the penal institution to which the prisoner is being transferred and the length of the sentence, shall be forwarded to the command to which the member has been administratively assigned which shall maintain the health record until the prisoner has been discharged from the Service. A copy of the letter of transmittal shall also be forwarded to Commander (CGPC).

7. Creating an Additional Volume.

- a. Due to chronic medical conditions, long narrative summaries, medical boards, etc., the record may fill to capacity which may cause the loss or damage to new records.
- b. Procedures for creating a second volume:
 - (1) Obtain a new Health Record (CG-3443) and transcribe the information from the original jacket.

- (2) Write "VOLUME II" in bold print in the lower left corner of the new jacket cover. Insert forms required by this chapter.
- (3) Write "VOLUME I" in bold print in the lower left corner of the original jacket cover.
- (4) Transfer all documents pertaining to current or chronic illness to the new record.
- (5) Remove the most recent SF-600 from VOLUME I and place it in VOLUME II. Insert a blank SF-600 on top of the remaining forms in VOLUME I and draw a diagonal line across the page. Enter the following on this line:

CLOSED. NO FURTHER ENTRIES IN THIS RECORD. REFER TO
VOLUME II.
- (6) Insert the most recent Report of Medical Examination (DD-2808) and the Report of Medical History (DD-2807-1) into VOLUME II.
- (7) Transcribe the immunization and HIV test date information onto a blank SF-601 and insert it in the appropriate section of VOLUME II.
- (8) Place the original Problem Summary List (NAVMED 6150/20) into VOLUME II and a copy of this form in VOLUME I with the annotation, "CLOSED. NO FURTHER ENTRIES.", below the last entry.
- (9) Place the original Chronological Record of Service (CG 4057) in VOLUME II and a copy in VOLUME I.

8. Lost, Damaged, or Destroyed Health Records.

- a. If a health record is lost or destroyed, a complete new health record shall be opened by the unit health record custodian. The designation "REPLACEMENT" shall be stamped or marked on the cover. If the missing health record should be recovered, any additional information or entries in the replacement record shall be inserted in the old record.
- b. Health records which become illegible, thus destroying their value as permanent records, shall be restored and duplicated. The duplicate shall, as nearly as possible, be an exact copy of the original record before such record becomes illegible. Take particular care in transcribing the date on DD-2808 into the new record as such information may be required by the Department of Veterans Affairs to determine the individual's right to pension or other Federal benefits. Stamp or mark "DUPLICATE" on the cover of the new record. Explain the circumstances necessitating the duplication on an SF-600. Forward health records replaced by duplicate records to CGPC-adm-3.

9. Accuracy and Completeness Check.

- a. Upon transfer of an individual, the health record custodian at both the detaching unit and the receiving unit shall inspect the health record for accuracy and completeness, in accordance with the following guidelines:
 - (1) that all immunizations are up-to-date (See Immunizations and Chemoprophylaxis, COMDTINST 6230.4 (series));

- (2) that PPD screening is current in accordance with Section 7-D of this Manual;
 - (3) that all required audiograms are completed, especially on personnel involved in the hearing conservation program;
 - (4) that required forms have been properly completed and are in the correct order;
 - (5) that all deficiencies in physical requirements shall be scheduled for correction, all missing forms shall be replaced, and all other clerical or administrative errors corrected; and
 - (6) that all OMSEP requirements are met.
- b. The health record custodian shall ensure that all identified deficiencies are corrected immediately. Appointments shall be scheduled and the individual's supervisor notified of the need to correct deficiencies as soon as possible.
 - c. Upon separation of the individual from the Service, the unit terminating the health record will inspect the health record, correct all errors, fill in omissions, and make sure the patient identification information is completed on all forms.

Section B - Health Record Forms.

1. **CG-3443 (Health Record Cover)**. See Encl (1), pg.4-1. Each patient's health record shall be maintained in a CG-3443 (Health Record Cover). The CG-3443 shall be completed according to the following instructions:
 - a. Last Name. Record in all capital letters.
 - b. Given Name(s). Record given name(s) in full without abbreviations. If the individual has no middle name or initial then use the lower case letter "n" in parentheses (n). If the individual has only a middle initial(s) record each initial in quotation marks. When "Jr." or "II" or other similar designations are used they shall appear after the middle name or initial.

DOE John Buck Jr.

Surname First Name Middle Name

- c. Beneficiary. Enter the appropriate beneficiary code to describe the patient (enter "20" for active duty members).
 - (1) 01 to 19 - Dependent children in order of birth
 - (2) 20 - Sponsor
 - (3) 30 - Spouse
 - (4) 31-39 - Unremarried former spouse
 - (5) 40 - Dependent mother (active duty)
 - (6) 45 - Dependent father (active duty)
 - (7) 50 - Dependent mother-in-law (active duty)
 - (8) 55 - Dependent father-in-law (active duty)
 - (9) 60 - Other dependents
 - (10) 80 - Humanitarian (non-eligible)
 - (11) 90 - Civilian employee
 - (12) 99 - Other eligible
- d. Sponsor's Social Security Number. Enter.
- e. Blood Type and Rh Factor. Enter the blood-type and Rh factor in the appropriate boxes. Use utmost caution when recording this information. If not known, complete a blood-type and Rh factor test as required.
- f. Special Status. Check the appropriate block to indicate whether the individual is in aviation or diving status, has a waiver, requires occupational monitoring, or has an allergy.
- g. Date of Birth. Enter year, month and day (e.g., 51/02/07).

- h. Local Use. Use the spaces provided below the sensitivity sticker location for local use information such as rank, unit, etc. as needed, **and/or for the HIPAA Notice of Privacy Practices Acknowledgement sticker**.
2. CG-5266 (Drug Sensitivity Sticker).
- a. General. Form CG-5266 should be initiated for anyone having documented history of sensitivity or hypersensitivity to specific drugs, serums, or vaccines, including PPD converters. Other non-drug allergies should be indicated on this form only if they will affect potential therapy (e.g., egg yolks). Every effort shall be made to verify the reported sensitivity and to confirm that it is allergic in nature.
 - b. Detailed Instructions.
 - (1) Prepare two originals. (One each for the health and dental records.)
 - (2) List the name of each drug, serum, vaccine, or anesthetic indicated on the DD-2766 Adult Preventive and Chronic Care Flowsheet.
 - (3) Affix the CG-5266 vertically to the indicated location on the health record cover (form CG-3443) and vertically to the lower left corner on the front of the dental record cover (CG-3443-2).
3. DD2766 (Adult Preventive and Chronic Care Flowsheet Form). See Encl (1), pg 4-2.
- a. General. The Adult Preventive and Chronic Care Flowsheet Form documents significant/chronic health problems, allergies, chronic medications, hospitalizations/surgeries, health counseling, immunizations, PPD, DNA & HIV testing, screening (preventive medicine) exams, other medical readiness items (such as blood type, G6PD, sickle cell, glasses, dental exam, etc), and chart audits. In-house training sessions should be conducted prior to the implementation of this form.
 - b. Detailed Instructions. DD2276 should be inserted as the first page of the medical record and all sections completed by the health care provider with the following guidelines exceptions:
 - (1) Information from previous Problem Summary Lists should be copied and updated onto the DD2276 as it is placed in the health record.
 - (2) If the patient is not allergic to any drugs, indicate NKDA (no known drug allergies), in block 1.a.
 - (3) Sections 8.a., 10.e. and 10.i. are not required to be completed.
 - (4) Use a pencil to darken the circles on Section 7, Screening Exam.
 - (5) The medical officer should enter the date and location of every deployment the member participates in Section 11, Pre/Post Deployment History. Pre and post deployment questionnaires are documented in Section 11 for participants in DOD deployment.

- (2) that PPD screening is current in accordance with Section 7-D of this Manual;
 - (3) that all required audiograms are completed, especially on personnel involved in the hearing conservation program;
 - (4) that required forms have been properly completed and are in the correct order;
 - (5) that all deficiencies in physical requirements shall be scheduled for correction, all missing forms shall be replaced, and all other clerical or administrative errors corrected; and
 - (6) that all OMSEP requirements are met.
- b. The health record custodian shall ensure that all identified deficiencies are corrected immediately. Appointments shall be scheduled and the individual's supervisor notified of the need to correct deficiencies as soon as possible.
 - c. Upon separation of the individual from the Service, the unit terminating the health record will inspect the health record, correct all errors, fill in omissions, and make sure the patient identification information is completed on all forms.

4. **SF-600 (Chronological Record of Medical Care)**. See Encl (1), pg 4-6.

a. **General**.

- (1) This form provides a current, concise, and comprehensive record of a member's medical history. Properly maintained, the SF-600 should: aid in evaluating a patient's physical condition; greatly reduce correspondence to obtain medical records; eliminate unnecessary repetition of expensive diagnostic procedures; and serve as an invaluable permanent record of health care received. The SF-600 shall be continuous and include the following information as indicated: complaints; duration of illness or injury, physical findings, clinical course, results of special examinations; treatment; physical fitness at time of disposition; and disposition. The SF-600 also serves as the patient's prescription from which pharmacy services are provided.
- (2) When a new SF-600 is initiated, complete the identification block with the name (last, first, middle initial), sex (M or F), year of birth, component (active duty or reserve), service (USCG, USN, USA, etc.), Social Security Number, and the member's grade/rate and organization at the time the form is completed.
- (3) File SF-600's on the right side of the medical record with the most current SF-600 on top.
- (4) Enter sick call entries on SF-600 in the following SOAP format

SOAP METHOD OF SICK CALL WRITE UPS

S: (Subjective).

cc: (Chief Complaint) sore throat, cough, diarrhea, etc.

hpi: (History Present Illness) onset of symptoms, all problems, review of symptoms

pmh: (Past Medical History) any related problems in past that may be present with chief complaint

fh: (Family History) any diseases, chronic/acute, possibly related to present complaint

all: (Allergies) any known allergies to drugs/medications, etc.

O: (Objective).

First visual assessment/evaluation of the patient's general appearance: limping, bleeding, doubled over, etc.

PE: All results of physical exam, vital signs, lab, x-ray, and any other study results.

A: (Assessment).

Imp: (Impression, Diagnosis) includes R/O (rule out)

NOTE: THIS IS TO INCLUDE, AFTER IMPRESSION, WHAT YOU ARE GOING TO DO NOW AND WHY--SUCH AS, SUTURING, TOURNIQUET, ETC.

P: (Plan).

List of medications given, lab, x-ray, special studies ordered, duty status, return appointments, referrals, etc.

- (5) The entries for all treatments shall be complete with regard to place, date, problem number (if appropriate), number of sick days, diagnosis of all conditions for which treated and signature of individual furnishing treatment. Note all facts concerning the origin of the disease, pregnancy status, symptoms, course, treatment, and if a conflicting opinion is expressed subsequently by the same, or another medical officer, fully state the reason for such change. The record need not be voluminous, but it shall be thorough, concise, clearly phrased, and complete in each case. All entries, including signatures, must be legible.
 - (6) When a member is injured or contracts a disease while on leave, or when for any other reason the facts concerning an injury or sickness have not been entered in the individual's health record, the record custodian shall ascertain the facts in the case and make the necessary entries on SF-600. Discuss and document the instructions given to the patient. Include the intended treatment and, as appropriate, possible alternative treatments, possible complications, and long term prognosis. Information regarding previous treatments should be entered giving the following: date, place, and full details of treatment; laboratory reports; x-ray results; etc. The following shall also be entered:
 - (7) "Date:
"Transcribed From Official Records.
- | Signature/Rate | Duty Station of Transcriber" |
|-----------------------|-------------------------------------|
|-----------------------|-------------------------------------|
- (8) When an individual is required to carry the PHS-731, enter a statement of acknowledgment on the SF-600.
 - (9) When an individual is diagnosed as having a Sexually Transmitted Disease (STD) make an entry to record that an interview was conducted and that the following was discussed with the patient:
 - (a) symptoms,
 - (b) complications,
 - (c) treatments, and contacts.

5. Treatment at Other Than Unit Assigned. When an activity furnishes sick call treatment to an individual whose health record is not available, an entry shall be made on a new SF-600 and forwarded to the individual's duty station for inclusion in the health record.
6. DD-2808 (Report of Medical Examination). See Encl (1), pg. 4-7.
 - a. Purpose. The DD 2808 is used to record physical examination results to determine whether an examinee does, or does not, meet the standards established for the type of physical examination administered (i.e., initial enlistment, officer programs, retention, release from active duty, diving, aviation, retirement, etc.). The SF-88 is no longer applicable.
 - b. Preparation.
 - (1) When Prepared. DD-2808 shall be prepared and submitted to the reviewing authority whenever a complete physical examination is required.
 - (2) Required Entries. Certain groups of personnel are required to meet physical standards somewhat different from other groups. Accordingly, the use of all the spaces or use of the same spaces on the DD-2808 is not necessarily required for reporting the results of the various categories of physical examinations. If a certain item of the medical examination is required and facilities for accomplishing it are not available, an entry "NFA" (No Facilities Available) shall be made in the appropriate space. An entry "NE" (Not Evaluated) shall be made in the appropriate space for any item of the clinical evaluation (Items 17-42) which was not evaluated. For other items listed on the DD-2808 which were not required for a particular category of physical examination, an entry "NI" (Not Indicated) or "NA" (Not Applicable), shall be made in the appropriate space. Reference should be made to other provisions of Chapter 3, which prescribe the nature and scope of each physical examination and indicate the applicability of items of the DD-2808 to the particular program. Unless otherwise indicated by such provisions, the minimum requirements for completing the DD-2808 are:
 - (a) All Examinations. Items 1-44, 45-63, 66, and 71a, shall be completed for all physical examinations, if facilities are available. Item 41, shall be completed for all female personnel.
 - (b) Aviation Personnel. Additionally, Items 64, 65, and 66-70 and 72b shall be completed for physical examinations of aviation personnel.
 - (3) A physical examination must be thorough, recorded accurately, and contain sufficient information to substantiate the final recommendation. Before signing and forwarding, the examiner shall review the completed DD-2808 for completeness and accuracy. Failure to do so reflects significantly on the examiner's clinical and/or administrative attention to detail. Remember that the reviewing authority does not have the advantage of a direct examination

and must rely on the examiner's written record and appropriate additional information in arriving at a decision.

c. Details for Entries on DD-2808.

- (1) **Item 1: Date of Examination.** Enter date in format - 02Aug15.
- (2) **Item 2: Social Security Number.** Enter the nine digits of their SSN.
- (3) **Item 3: Last Name.** Last Name - First Name - Middle Name. Record the surname in all capital letters. Record the given name(s) in full without abbreviation. If the individual's first or middle name consists only of an initial, enclose each initial in quotation marks (i.e., MANUEL, Thomas "W"). If the individual has no middle name, enter the letter "(n)" in parenthesis [i.e., TARVIN, Laurie (n)]. Designations, such as, "Jr." or "II" shall appear after the middle name or initial. In the absence of a middle name or initial, these designations shall appear after the "(n)."
- (4) **Item 4: Home Address.** Enter the evaluatee's present residence and not the home of record.
- (5) **Item 5: Home Telephone Number.** NA
- (6) **Item 6: Grade.** Use official abbreviation of the current grade or rate. Example: HSCS; LTJG. If not a service member, enter "civilian."
- (7) **Item 7: Date of Birth.** (e.g.57Sep04).
- (8) **Item 8: Age.** Enter age.
- (9) **Item 9: Sex.** Mark one or the other of the boxes.
- (10) **Item 10: Race.** Mark the box next to the racial or ethnic group of which member belongs.
- (11) **Item 11: Total Years of Government Service.** Enter years and months (e.g., 06 yrs 04 mo's).
- (12) **Item 12: Agency.** Enter the OPFAC number of the unit to which the examinee is attached.
- (13) **Item 13: Organization and UIC/Code.** List name of ship or station to which the examinee is assigned. Initial entry into Service; enter recruiting office concerned.
- (14) **Item 14a: Rating or Specialty.** NA
- (15) **Item 14b: Total Flying Time.** Aviators only or NA.
- (16) **Item 14c: Last six months.** Aviators only or NA.
- (17) **Item 15a: Service.** Mark a box next to appropriate service.
- (18) **Item 15b: Component.** Mark a box next to appropriate component.

- (19) **Item 15c: Purpose of Examination.** Mark the box and corresponds to the appropriate purpose(s) of the examination. If not listed, mark “Other,” and explain above the box such as: Diving Applicant; Biennial Aircrew; etc. For a medical board, indicate whether it is an IMB (Initial Medical Board)/DMB (Disposition Medical Board), etc. Do not use the incomplete terms “flight physical,” “diving physical,” or “aviation physical.” Rather, use specific terms such as “Class I Aviation,” “Candidate for Flight Training,” “Class II Aircrew,” “Dive Candidate,” “Quinquennial Diving,” etc. Avoid nonstandard abbreviations. Differentiate between an applicant for a special program and a biennial physical for the same program. When necessary, continue under Item 73, Notes.
- (20) **Item 16: Examining Facility or Examiner.** For civilian or contract physician, enter the full name and address. For USMTF, enter only the facility name, city and state in which located.
- (21) **Item 17-42: Clinical Evaluation.** Check each item in appropriate column.
- (a) **Item 35:** Is continued on lower right side (Feet), circle appropriate category.
- (22) **Item 43: Dental Defects and Disease.** For an oral examination as part of an accession physical, record whether or not the applicant is ‘Acceptable’ or ‘Not Acceptable’. Refer to the standards described in Chapter 3 Section D-5 Physical standards for enlistment, appointment, and induction. Enter disqualifying defects in detail in Item 73. Record the Dental Classification. Refer to Chapter 4 Section C-3-c for definitions of dental classes. For routine physical examinations, record only the Dental Classification. When oral disease or dental defects are discovered on examination of active duty member personnel, suitable recommendations will be made for instituting corrective measures. A copy of form SF-603, Dental Record does not need to be attached to the DD-2808.
- (23) **Item 44: Notes.** Describe every abnormality from Items 17-43 in detail. Enter pertinent item number before each comment. Continue in Item 73 and use Continuation Sheet (SF-507), if necessary.
- (24) **Item 45: Laboratory Findings.** Enter all laboratory results in quantitative values.
- (a) **Urinalysis.** Enter specific gravity and results of albumin, sugar and if required, microscopic tests in the indicated spaces.
- (b) **Item 46: Urine HCG.** If applicable.
- (c) **Item 47: H/H.** Enter either the hematocrit or the hemoglobin results.
- (d) **Item 48: Blood Type.** If applicable.
- (e) **Item 49: HIV.** Enter date drawn only in the results section.

- (f) **Item 50: Drugs Test Specimen ID Label.** NA
- (g) **Item 51: Alcohol.** NA
- (h) **Item 52: Other.** Enter all other tests performed and their results which are not indicated on the form and which were performed in connection with the physical examination (e.g., sickle cell test, PAP test, PPD, EKG, Chest X-ray results, etc.). The results will be continued in Item 73 or on Continuation Sheet (SF 507), if necessary. If provided on the lab report, include "normal" range values for all tests performed by a civilian or military lab. Use quantitative values and avoid vague terms such as "WNL" or other such qualitative forms.
- (25) **Item 53: Height.** Measure without shoes and record to the nearest one-half centimeter ((one-half inch)
- (26) **Item 54: Weight.** Measure with the evaluatee in under garments and record results to the nearest kilogram (pound).
- (27) **Item 55: Min Weight-Max weight, Max BF%.** NA
- (28) **Item 56: Temperature.** Leave Blank. NI
- (29) **Item 57: Pulse.** Record the actual pulse rate.
- (30) **Item 58: Blood Pressure.** Record the actual value in numerals for both systolic and diastolic.
- (31) **Item 59: Red/Green.** NA
- (32) **Item 60: Other Vision Test.** If applicable.
- (33) **Item 61: Distant Vision.** Test and record using the Snellen scale. Record vision in the form of a fraction and in round numbers, that is 20/20, 20/40, not 20/20-2 or 20/40-3.
- (34) **Item 62: Refraction.** Enter the lens prescription when the evaluatee wears (or requires) lenses for correction of visual acuity. Do not enter the term "lenses."
- (35) **Item 63: Near Vision.** Test and record using the Snellen scale. (See item 61).
- (36) **Item 64: Heterophoria.** Enter when indicated.
- (37) **Item 65: Accommodation.** Enter when indicated.
- (38) **Item 66: Color Vision.** Color Vision. Enter the test used and the results.

- (a) Farnsworth Lantern. Record the results as "Passed FALANT" or "Failed FALANT" followed by the fraction of correct over total (i.e., 9/9 or 17/18).
 - (b) Pseudoisochromatic Plates (PIP). Record results as "Passed PIP" or "Failed PIP" followed by the fraction of correct over total (i.e., 12/14 or 14/14).
 - (c) Enter "Passed on record" or "failed on record" if the results of a previous PIP or FALANT examination are available on record for review.
- (39) **Item 67: Depth Perception.** When indicated, enter test used in left portion of Item 67.
- (a) AFVT. In the appropriate space in the right-hand portion of Item 65, record the letter designation of the highest group passed (i.e., Passed F).
 - (b) Verhoeff. In the appropriate space in right-hand portion of Item 34, record perfect score as 16/16.
- (40) **Item 68: Field of Vision.** Enter when indicated.
- (41) **Item 69: Night Vision.** Enter when indicated.
- (42) **Item 70: Intraocular Tension.** When indicated, enter the results in millimeters of mercury.
- (43) **Item 71: Audiometer.** Required on ALL physical examinations. Use ANSI 1969 standards, do not use ISO or ASA standards.
- (a) **Item 71a:** Current
 - (b) **Item 71b:** If applicable.
- (44) **Item 72a: Reading Aloud Test.** If applicable.
- (45) **Item 72b: Valsalva.** When indicated mark either SAT or UNSAT.
- (46) **Item 73: Notes and Significant or Interval History.** Use this space for recording items such as:
- (a) any pertinent medical history;
 - (b) summary of any condition which is likely to recur or cause more than minimal loss of duty time;
 - (c) wrist measurements;
 - (d) most recent HIV antibody test date (see Chapter 3-C-20.b.(9) of this Manual);
 - (e) date of PPD and results; and
 - (f) Preventive Medicine stamp per Use of Preventive Medicine Stamp, COMDTINST 6200.11(series), for exams originating in Coast Guard sickbays and clinics.

- (47) **Item 74a: Examinee's Qualification.** State whether or not the examinee is qualified for the purpose of the examination. If the purpose for the examination is an IMB or DMB, state whether or not the examinee is qualified or not qualified for retention and to perform the duties of his/her rank/rate at sea and foreign shores.
- (48) **Item 74b: Physical profile.** Leave blank.
- (49) **Item 75: I have been advised of my disqualifying condition.** If indicated, have evaluatee sign and date.
- (50) **Item 76: Significant or Disqualifying Defects.** Leave Blank
- (51) **Item 77: Summary of Defects and Diagnoses.** List ALL defects in order to protect both the Government, and evaluatee, in the event of future disability compensation claims. All defects listed which are not considered disqualifying shall be so indicated by the abbreviation NCD (Not Considered Disqualifying). When an individual has a disease or other physical condition that, although not disqualifying, requires medical or dental treatment clearly state the nature of the condition and the need for treatment. If a medical or dental condition is disqualifying, and treatment is scheduled to be completed prior to transfer to overseas or sea duty, indicate the date the member is expected to be fully qualified, e.g., "Dental appointment(s) scheduled, patient will be class I (dentally qualified) by (date)". **Leave Profile Serial, RBJ, Qualified, and Waiver blocks blank.**
- (52) **Item 78: Recommendations.** Indicate any medical or dental recommendations. Specify the particular type of further medical or dental specialist examination indicated (use SF-507, if necessary).
- (53) **Item 79: MEPS Workload.** Leave Blank.
- (54) **Item 80: Medical Inspection Date.** Leave Blank.
- (55) **Item 81-84: Names and Signature of Examiners.** The name, grade, branch of Service, and status of each medical and dental examiner shall be typewritten, printed, or stamped in the left section. Each examiner shall sign using ballpoint pen or ink pen (black or blue-black ink only) in the appropriate section. Do not use facsimile signature stamps. When attachment sheets are used as a supplement or continuation to the report, they shall be serially number (both sides); however, indicate only the actual number of attached sheets in the bottom right **block 87** on DD-2808.
- (56) **Item 85: Administrative Review.** The person who reviews the PE for accuracy, prior to submitting for approval shall sign and date.
- (57) **Item 86: Waiver Granted.** Leave Blank.
- (58) **Item 87: Number of attached Sheets.** Fill in with appropriate number of forms attached.

7. **DD-2807-1 (Report of Medical History)**. See Encl (1), pg. 4-7.

- a. **Purpose.** DD-2807-1 provides a standardized report of the examinee's medical history to help the examiner evaluate the individual's total physical condition, and to establish the presence of potentially disabling conditions which are not immediately apparent upon physical examination. In preparing the form, encourage the examinee to enter all medical problems or conditions experienced, no matter how minor they may be. The examiner must investigate and evaluate all positive medical history indicated on the form.
- b. **Preparation and Submission of DD-2807-1.** Prepare and submit DD-2807-1 with all physical examinations except: Periodic OMSEP and Substitution/Overseas/Sea Duty Modified Physical Examination.
- c. **Preparation Procedures.** DD-2807-1 shall be prepared by the examinee and the examining medical officer.
 - (1) The examinee shall furnish a true account of all injuries, illnesses, operations, and treatments since birth. False statements or willful omissions in completing the DD-2807-1 may result in separation from the Service upon arrival at the Academy, Recruit Training Center, Officer Candidate School, or later in the individual's career.
 - (2) A copy of the DD-2807-1 must be included in the member's health record. Entries must be printed, in the examinee's and examiner's own handwriting, using either ball-point pen or ink pen (black or dark blue). Pencils or felt-tip pens will not be used. Information in the numbered blocks on the form will be entered in the following manner:
 - (a) **Item 1: Last Name, First, Middle Name.** SMITH, Hannibell H. Record the surname in all capital letters. Record the given name(s) in full, without abbreviation. If the individual's first or middle name consists only of an initial, enclose each initial within quotation marks. If the individual has no middle name, enter the letter "(n)" in parenthesis. Designations such as "Jr." or "II" will appear after the middle name or initial or after "(n)" if there is no middle name.
 - (b) **Item 2: Social Security Number.** Enter SSN.
 - (c) **Item 3: Enter date format** –2001Sep04.
 - (d) **Item 4a: Home Address.** Enter the evaluatee's present residence and not the home of record.
 - (e) **Item 4b: Home Telephone.** Enter home phone number.
 - (f) **Item 5: Examining Location and Address.** For civilian or contract physician, enter the full name and address. For a USMTF, enter only the facility name and the city and state in which located.

- (g) **Item 6a: Service.** Mark a box next to the appropriate service.
- (h) **Item 6b: Component.** Mark a box next to the appropriate component.
- (i) **Item 6c: Purpose of Examination.** Mark a box next to the appropriate purpose(s) of the examination. If not listed, mark “Other” and explain above the box such as: Diving Applicant; Biennial Aircrew; etc. For a medical board, indicate whether it is an IMB (Initial Medical Board)/DMB (Disposition Medical Board), etc. Do not use the incomplete terms “flight physical,” “diving physical,” or “aviation physical.” Avoid nonstandard abbreviations. Differentiate between an applicant for a special program and a biennial physical for the same program.
- (j) **Item 7a: Position.** Use official abbreviation of current grade or rate, branch of the Service, class and status; i.e., regular, reserve, or retired and if active or inactive. Example: HSCM, USCG; LTJG, USCGR; HSC, USCG (RET); HS3, USCG (TEMPRET). If not a Service member, enter "civilian."
- (k) **Item 7b: Usual Occupation.** List current occupation.
- (l) **Item 8: Current Medications.** List all current medications including over the counter meds.
- (m) **Item 9: Allergies.** List any allergies to insect bites/stings, foods medicine or other substances.
- (n) **Item 10 to 28.** Check appropriate box.
- (o) **Item 29: Explanation of “Yes” Answer(s).** Describe all “yes” answers from section 10-28. Include date(s) of problems, name of doctor(s), and /or hospitals(s), treatment given and current medical status.
 - 1 Append Item 29 to include: The statement to present health and a list of medications presently being taken by the examinee. For individuals receiving examinations more frequently than quinquennial, there is often little change in the medical history from year to year. As an alternative to having the examinee complete Section 10-28 of the DD-2807-1 at a periodic examination, the following statement may be entered in Item 29 and initialed by the person undergoing the examination.
 “I have reviewed my previous Report of Medical History and there have been no changes since my last medical examination, except as noted below.” _____(initials)
- (p) **Item 30. Examiner’s Summary and Elaboration of all Pertinent Data.** Prior to performing the physical examination, the examiner will review the completeness of the information furnished on the DD-2807-1. When this is done, summarize the medical history under

(**Item 30a. Comments**) as outlined below and then sign the form. If additional space is needed, use Continuation Sheet, SF-507.

- (q) Do not use the term "usual childhood illnesses"; however, childhood illnesses (those occurring before age 12) may be grouped together enumerating each one. Incidents, other than those occurring in childhood, shall have the date recorded rather than the examinee's age. Do not use "NS" or "non-symptomatic" for items of history. Use "NCNS," "No Comp., No Seq." after items of recorded history where applicable. Elaborate on all items of history answered affirmatively except "Do you have vision in both eyes". The following specific questions shall also be asked on examination for initial entry into the Coast Guard, and for aviation and diving duty applicants:

- 1 "Is there a history of diabetes in your family (parent, sibling, or more than one grandparent)?"
- 2 "Is there a history of psychosis in your family (parent or sibling)?"
- 3 "Do you now or have you ever worn contact lenses?"
- 4 "Do you now or have you ever used or experimented with any drug, other than as prescribed by a physician (to include LSD, marijuana, hashish, narcotics, or other dangerous drugs as determined by the Attorney General of the United States)?"
- 5 "Have you ever required the use of an orthodontic appliance attached to your teeth or a retainer appliance? Month and year last worn? Are they still necessary?"
- 6 "Are there any other items of medical or surgical history that you have not mentioned?" All affirmative answers to the above questions shall be fully elaborated in Item 25. Negative replies to the above questions shall be summarized as follows: "Examinee denies history of psychosis, use of drugs, history of wearing of contact lenses, requirement for any orthodontic appliance, all other significant medical or surgical history; family history of diabetes." A rubber stamp or the overprinting of this information in Item 25 is recommended.

- (3) Distribution. Attach the original DD-2807-1 to the original DD-2808 and submit to reviewing authority. A copy of the DD-2807-1 and DD-2808 shall be kept on file at the unit pending the return of the approved DD-2807-1 and DD-2808. After review and endorsement, the reviewing authority shall forward the original DD-2807-1 and DD-2808 to the members parent command for insertion into the members health record.

8. **SF-558 (Emergency Care and Treatment) (Rev 9-96)**. See Encl (1), pg. 4-13. This form provides a comprehensive yet concise record of emergency health care. It shall be used whenever an individual receives emergency treatment. Detailed instructions for completing the form are as follows:

- a. Patient's Home Address or Duty Station. Complete all blocks in this section.
- b. Arrival. Record the date and time the patient arrived at the clinic or emergency room for care.
- c. Transportation to Facility. Record the name of the ambulance company or unit that transported the patient for care, if appropriate. If patient was not transported by ambulance or other emergency vehicle, enter "N/A".
- d. Third Party Insurance. List detailed insurance if known by patient. If potential third party liability exists, forward a copy of SF-558 to Commandant (G-WRP-2). Note: Disregard DD2568 in chart, enter N/A).
- e. Current Medications. List all medications patient is presently taking.
- f. Allergies. Record any substance or drug to which the patient has a known or suspected allergy. If none, enter "NKA" (No Known Allergy).
- g. Injury or Occupational Illness. Most fields. When, refers to date injury was sustained. Where, refers to location injury occurred. How, refers to what happened (briefly).
- h. Emergency Room Visit. Self-Explanatory.
- i. Date of Last Tetanus Shot. Self-Explanatory.
- j. Chief Complaint. Record a brief description of why the patient is seeking health care.
- k. Category of Treatment. If Condition is Result of Accident/Injury. Check the block that best describes the patients' condition upon arrival.
 - (1) Emergent. A condition which requires immediate medical attention and for which delay is harmful to the patient; such a disorder is acute and potentially threatens life or function.
 - (2) Urgent. A condition which requires medical attention within a few hours or danger can ensue; such a disorder is acute but not necessarily severe.
 - (3) Non-Urgent. A condition which does not require the immediate resources of an emergency medical services system; such a disorder is minor or non-acute
- l. Vital Signs. Take and record all vital signs. Indicate the time vitals were taken. Use 24-hour clock annotation i.e. 0215.
- m. Lab Orders and X-Ray Orders. Self-Explanatory, check appropriate box.
- n. Orders. List orders given by provider. Record all medications, appointments made. Or any other follow-up plans.
- o. Disposition. Check appropriate box. Ensure patient understands this section.
- p. Patient/Discharge Instructions. Be specific. Ensure patient understands instructions given.

- q. Patients Signature and Date. Have the patient or person accompanying the patient sign the form. This signature only acknowledges that instructions were given to the patient.
 - r. Time Seen by Provider. Record the time when the patient received treatment. Use 24-hour clock annotation i.e. 0215.
 - s. Test Results. Record results of tests ordered on patient.
 - t. Provider History/Physical. Self-explanatory, use standard S.O.A.P. format.
 - u. Consult With. List all individuals that on-scene provider received medical advice from. Example Dr. Richard Smith.
 - v. Diagnosis. Record patient diagnosis.
 - w. Providers Signature and Date. The medical officer or other health care provider shall sign and date the form.
 - x. Codes. List all ICD-9 codes applicable to the patient.
 - y. Patients' Identification. Ensure all patient identification information is entered.
9. [DD-2215 Reference Audiogram](#). Place form in section V of the Health Record.
 10. [DD-2216 Hearing Conservation Data](#). Place form in section V of the Health Record.
 11. [Audiogram Results](#). The Microprocessor will generate a legal archival test result strip, which shall be fastened to a separate SF-514, Clinical Record-Laboratory report form, dedicated to this purpose and filed under section V of the Health Record. Label this SF-514 "Hearing Conservation Program" across the bottom.
 - a. All test result strips shall be placed sequentially onto form SF-514 in left to right formation overlapping 2/3 of the last audiogram.
 12. [SF-502 \(Narrative Summary\)](#). See Encl (1), pg.4-15. SF-502's are used for a variety of purposes, such as:
 - a. to summarize the important facts about a patient's hospitalization;
 - b. to summarize the findings of a medical board; or
 - c. to report the results of a Board of Flight Surgeons.

If received subsequent to the individual's discharge from the hospital, it shall be inserted in the health record immediately upon receipt.
 13. [NAVMED 6100/1 \(Medical Board Report Cover Sheet\)](#).
 - a. The NAVMED 6100/1 is used in preparing a medical board. A copy of the NAVMED 6100/1 and the complete medical board shall be inserted into the individual's health record.
 - b. Detailed instructions for preparing and distributing this form are contained in Physical Disability Evaluation System, COMDTINST M1850.2 (series).

14. **SF-513 (Consultation Sheet)**. See Encl (1), pg 4-16.

- a. Purpose. SF-513 is used whenever a patient is referred to another facility for evaluation.
- b. Detailed Instructions. Complete the form as follows:
 - (1) To. Facility or department to which the patient is being referred.
 - (2) From. Unit referring the patient.
 - (3) Date of Request. Self-explanatory.
 - (4) Reason for Request. Specify the reason for referring the patient, i.e., chest pains, infected sebaceous cyst, etc.
 - (5) Provisional Diagnosis. Self-explanatory.
 - (6) Doctor's Signature. Must be signed by a medical officer, dental officer, or health services department representative. Accompanying this signature should be the qualifying degree of the individual requesting the consult.
 - (7) Approved. Leave Blank.
 - (8) Place of Consultation. Check the appropriate block.
 - (9) Emergency/Routine. Check the appropriate block.
 - (10) Identification No. Enter the patient's SSN.
 - (11) Organization. Enter patient's branch of service.
 - (12) Register No. If inpatient, enter the appropriate register number. If outpatient, leave blank.
 - (13) Ward No. If outpatient enter "OP." If inpatient, enter appropriate ward number.
 - (14) Patient's Identification. Enter the appropriate patient identification information.
 - (15) The remainder of the form is completed by the consultant.
- c. When the consultation sheet (SF-513) is completed and returned by the consultant, the following actions are required:
 - (1) Originator shall review and sign the SF-513;
 - (2) The SF-513 shall then be filed in the appropriate dental or medical section of the health record.

15. **SF-520 (Electrocardiographic Report).** See Encl (1), pg.4-17.

- a. Purpose. SF-520 is used to report the results of all electrocardiograms.
- b. Detailed Instructions. The individual performing the electrocardiogram shall complete the form as follows:
 - (1) Previous ECG. Check appropriate block
 - (2) Clinical Impression. Reason why the electrocardiogram was requested, e.g., chest pain, physical examination, etc.
 - (3) Medication. Enter any medications that the patient is taking.
 - (4) Emergency/Routine. Check appropriate block.
 - (5) Bedside/Ambulant. Check appropriate block.
 - (6) Age. Enter patient's age as of last birthday.
 - (7) Sex. Enter "M" or "F," as appropriate.
 - (8) Race. Leave blank.
 - (9) Height. Enter to nearest one-half centimeter (one-half inch).
 - (10) Weight. Enter to the nearest kilogram (pound).
 - (11) B.P. Enter recumbent blood pressure.
 - (12) Signature of Ward Physician. Signature of medical officer ordering the electrocardiogram.
 - (13) Date. Date the ECG was performed using appropriate format.
 - (14) Register No. Enter patient's social security number.
 - (15) Ward No. Enter "OP" (outpatient) or appropriate ward no.
 - (16) Patient's Identification. Enter the appropriate patient identification information.
 - (17) The remainder of the form is completed by the medical officer evaluating the electrocardiogram.
- c. The baseline ECG shall be appropriately marked "Baseline ECG."

16. **SF-515 (Tissue Examination).** See Encl (1), pg.4-18.

- a. Prepare a SF-515 whenever a tissue specimen is forwarded to a laboratory for examination.
- b. Ensure patient's identification information is completed.

17. **SF-541 (Gynecologic Cytology).** See Encl (1), pg.4-19.

- a. Prepare a SF-541 whenever a vaginal or cervical smear (PAP test) is forwarded to a laboratory for examination.

- b. Ensure patient's identification information is completed.
18. **SF-514 (Laboratory Reports)**. See Encl (1), pg.4-20.
- a. This is a display form for mounting graphic reports, automated printout reports, or printed reports associated with special equipment.
 - b. Attach the laboratory reports to the indicated spaces with the most recent on top.
 - c. Ensure patient's identification information is completed.
 - d. Clinical Record - Laboratory Report Display (SF-545). May be used in lieu of SF-514. This is a display form for mounting laboratory requests and report forms. When a patient will require the same type of test several times, a separate display sheet shall be used for each type of test. In low use situations, the various test result forms should be mounted on alternate strips 1, 3, 5, and 7.
 - (1) The following Standard Forms should be mounted serially on strips 1, 2, 3, 4, 5, 6, and 7:
 - (a) Chemistry I (SF-546),
 - (b) Hematology (SF-549),
 - (c) Urinalysis (SF-550), and
 - (d) Serology (SF-551).
 - (2) The following Standard Forms be mounted on alternate strips 1, 3, 5, and 7:
 - (a) Chemistry II (SF-547);
 - (b) Chemistry II (Urine) (SF-548);
 - (c) Parasitology (SF-552);
 - (d) Spinal Fluid (SF-555); and
 - (e) Immunohematology (SF-556).
 - e. In many instances there will be a mixed assortment of Standard Forms to be mounted in a patient's chart and obviously these should be mounted in the most practical sequence.
 - f. Instructions for attaching the laboratory report forms to this display sheet are printed at the bottom of the SF-545. A check mark in the space in the lower right corner identifies the name of the laboratory forms that are displayed on this sheet or indicates that a variety or assortment of forms is displayed on the sheet.
19. **SF-545a - Clinical Record - Laboratory Report Display for SF-553, SF-554, and SF-557.** This is a display form for mounting Microbiology I, Microbiology II, and miscellaneous forms for inclusion in the health record. It may be used, when indicated, in addition to SF-514.

20. SF-546 - 557 (Laboratory Requests).

- a. SF-546 (Chemistry I). Used to request most blood chemistry tests. Fill in the identification data as described previously. The specimen sources information is given by checking the box marked BLOOD or by specifying information in the position marked OTHER. The names of the blood chemistry tests are listed individually on this form. At the bottom of the list there is provision for ordering a battery or profile of tests. When requesting the identifying names of the battery or profile of tests must be written into the space provided. There is also space for writing in the names of other tests not specifically listed.
- b. SF-547 (Chemistry II). Used to request blood gas measurement, T3, T4, serum, iron binding capacity, glucose tolerance, and other chemistry tests. Fill in the identification data as described previously. The specimen source information is given by checking the box marked BLOOD or by specifying information in the position marked OTHER.
- c. SF-548 (Chemistry II, Urine). Used to request chemistry tests on urine specimens. The specimen interval information is given by checking the box marked 24 HOURS or by specifying information in the position marked OTHER.
- d. SF-549 (Hematology). Used to request routine hematology tests. The specimen source information is given by checking box marked VEIN, the box marked CAP for capillary, or by specifying information in the position marked OTHER.
- e. SF-550 (Urinalysis). Used to request urinalysis tests, including routine urinalysis with microscopic examination. The specimen source information is given by checking the box marked ROUTINE or by specifying information in the position marked OTHER. (Note that routine urinalysis may be ordered by simply placing an "X" in front of the word MICROSCOPIC in the requesting section.) The space marked PSP is for requesting and reporting phenolsulfonphthalein measurements. The space marked HCG is for requesting and reporting measurements of human chorionic gonadotropin.
- f. SF-551 (Serology). Used to request tests that measure serum antibodies, including tests for syphilis.
 - (1) The space marked RPR is for requesting and reporting measurements of the Rapid Reagent Card Test for Syphilis
 - (2) The space marked TA is for requesting and reporting measurements of the Latex Fixation Test for Thyroglobulin Antibodies.
 - (3) The space marked COLD AGG is for requesting and reporting of Cold Agglutinins.
 - (4) The space marked ASO is for requesting and reporting Antistreptolysin O titers.
 - (5) The space marked CRP is for requesting and reporting measurements of C Reactive Protein.

- (6) The space marked FTA-ABS is for requesting and reporting for fluorescent treponemal antibody-absorption test.
 - (7) The space marked FEBRILE AGG is for requesting and reporting measurements of Febrile Agglutinins.
 - (8) The space marked COMP FIX is for requesting and reporting Complement Fixation Tests. The name of the specific antibody should also be written in this space.
 - (9) The space marked HAI is for requesting and reporting Hemagglutination Inhibition Tests. The name of the specific antibody should also be written in this space.
- g. SF-552 (Parasitology). Used to request tests for intestinal parasites, malaria and other blood parasites, as well as most test on feces. Fill in identification data as described previously.
- h. SF-553 (Microbiology I). Used to request most bacteriological isolations and sensitivities.
- (1) The type of the patient's infection, according to origin, is indicated by checking one of the boxes in the space marked INFECTION in the upper right area of the form.
 - (2) The examination requested is indicated by checking either the box marked SMEAR, SENSITIVITY, CULTURE, or COLONY COUNT.
 - (3) The report of the examination is written or stamped on the form by the laboratory personnel.
 - (4) The names of the bacteria identified or isolated are listed in the space marked PREDOMINANT ORGANISM(S).
 - (5) The sensitivity listing and results are stamped or written in the space marked SENSITIVITY.
- i. SF-554 (Microbiology II). Used to request tests for fungi, acidfast bacillus (TB), and viruses.
- (1) The type of infection according to origin is indicated by checking one of the boxes in the space marked INFECTION.
 - (2) The examination(s) requested is checked in the sections for fungus test or AFB tests or viral cultures.
 - (3) The test results are stamped or written on the form by the laboratory personnel.
- j. SF-555 (Spinal Fluid). Used to request most spinal fluid tests.
- k. SF-556 (Immunohematology). Used to request blood grouping, typing, and blood bank tests.

1. SF-557 (Miscellaneous). Used to request and report tests such as electrophoresis and assays of coagulation factors, which are not ordered on other laboratory forms.
 - (1) Fill in the identification data as described previously.
 - (2) The specimen source is specifically described in the space marked SPECIMEN SOURCE.
 - (3) Write the name of the test requested in the request section of the form.
21. SF-519 (Radiographic Reports). See Encl (1), pg.4-21.
 - a. This is a display form for mounting Radiographic Reports (SF-519-A). Attach the SF-519-A to the indicated spaces, with the most recent report on top.
 - b. Use SF-519-A to request x-ray examinations. All patient data must be completed as indicated. Ensure that examinations requested are in standard terms or abbreviations. ALL pertinent clinical history, operations, physical findings, pregnancy status, and provisional diagnoses must be recorded in the appropriate space. This information is needed by the radiologist in order to render a proper interpretation of the film.
 - c. Complete the required patient's identification information.
22. DD-771 (Eyewear Prescription). See Encl (1), pg.4-22. Type DD-771 for clarity and to avoid errors in interpretation, using the following format:
 - a. Date. Enter as follows, 22 JAN 87, etc.
 - b. Order Number. Enter unit identifying number, issued by NOSTRA or Top Gun Fantasy Ray Ban, above the order number block. Complete order number block if desired.
 - c. To. Appropriate fabricating facility.
 - d. From. Enter complete unit address of unit ordering the eyewear.
 - e. Name, Service Number/Social Security Number. Enter as ALBERT, Michael W. HSC 123-45-6789.
 - f. Age. Self-explanatory.
 - g. Unit and Address. Enter complete mailing address of unit to which individual is attached. If retiree, use the individual's home or mailing address.
 - h. Active Duty, etc. Check appropriate block.
 - i. USA, USN, etc. Check appropriate block.
 - j. Spectacles. Check appropriate block.
 - k. Aviation Spectacles. Use this block only when ordering aviation frames. Check as appropriate:

- (1) N-15 tinted lenses;
- (2) Coated lenses (coated with an anti-glare compound) are not authorized for Coast Guard personnel.
- l. Other. Leave blank.
- m. Interpupillary Distance. Copy directly from patient's Prescription, previous DD-771, or SF-600.
- n. Eye Size. As above. (Not required for aviation goggles)
- o. Bridge Size. As above. (Not required for aviation goggles)
- p. Temple Length and Style. As above. (Not required for aviation goggles)
- q. Number of Pairs. Enter the number of pairs requested.
- r. Case. Enter the number of cases requested.
- s. Single Vision.
 - (1) Sphere. Copy directly from individual's prescription, previous DD-771, or SF-600 (+1.00, -1.25, etc.). Prescriptions are filled in multiples of 0.25 diopters only.
 - (2) Cylinder. As above, except that prescriptions or multivision lenses must be in "minus cylinder" form, (-0.50, -0.75, etc.).
 - (3) Axis. Copy directly from individual's prescription, previous DD-771, or SF-600. The axis must contain three (3) digits such as: 180, 090, 005, etc.
 - (4) Decentration. Need not be completed unless specified as a part of prescription.
 - (5) Prism. As indicated on individual's prescription, previous DD-771, or SF-600.
 - (6) Base. As above.
- t. Multivision. If the individual needs multivision lenses (bifocals, trifocals, etc.) then the prescription must be in minus cylinder form.
- u. Special Lenses or Frames. This block is used for special instructions or justification for aviation spectacles, or nonstandard lenses, and frames, etc.
 - (1) When replacement eyewear is ordered from a prescription extracted from the health record, enter the following entry in this block: "REPLACEMENT ORDER: PRESCRIPTION FROM REFRACTION PERFORMED ON DATE."
 - (2) When eyewear is ordered for recruits, enter the following entry in this block: "RECRUIT - PLEASE EXPEDITE."
 - (3) When tinted lenses are ordered for non-aviation personnel, enter a written justification in this block. "Tinted lenses STATE JUSTIFICATION."

- (4) When nonstandard temples or frames are ordered, enter type frame or temple requested, and justification:
 - (a) Riding Bow Cables, (Justification);
 - (b) Adjustable Nose Pads, (Justification).
 - (5) When an individual's pupillary distance is less than 60 mm it must be verified and an entry placed in this block: "PD of ____ verified and correct."
 - v. Signature of Approving Authority. Shall be signed by the senior medical officer, designated representative, or the commanding officer where no medical officer is present.
 - w. Signature of the Prescribing Officer. Shall be signed by the medical officer or person performing the refraction. When this is not possible, i.e., examination obtained from a civilian source, transcribed from the health record, etc., the person transcribing the information shall sign as prescribing officer. Flight surgeons may sign prescriptions as both the prescribing and approving authority.
23. **SF-601 (Immunization Record)**. See Encl (1), pg.4-23.
- a. All prophylactic immunizations; sensitivity tests; reactions to transfusions, drugs, sera, food and allergies, and blood typings shall be recorded on SF-601 and also on the PHS-731. The recordings shall be continued on the current record until additional space is required under any single category.
 - b. In such cases, insert a new SF-601 in the health record and retain the old SF-601. Concurrently, make a thorough verification of the entries and bring all immunizations up-to-date. Replacement of the current SF-601 is not required because of change in grade, rating, or status of the member concerned.
 - c. The name of the individual administering the immunization or test, or determining the nature of the sensitivity reaction, shall be typed or a rubber stamp used. Signatures on SF-601 are not required. However, in the event of their use, make sure they are legible.
 - d. The individual administering the immunizations is responsible for completing all entries in the appropriate section, including required entries on reactions.
 - e. Enter information concerning a determined hypersensitivity to an immunization or vaccine under "Remarks and Recommendations". Type appropriate entries (such as HYPERSENSITIVE TO TYPHOID) in capitals. Enter "HIV antibody testing done (enter date(s))".
 - f. For Yellow Fever vaccine, record the origin and batch number.
24. **SF-602 (Syphilis Record)**. See Encl (1), pg. 4-25.
- a. This form shall be prepared and inserted in the health record for each person for whom a confirmed diagnosis of syphilis or any of its complications or sequela has been established.

- b. The medical officer shall carefully and thoroughly explain to the patient the nature of the infection and the reasons why treatment, prolonged observation and the repeated performance of certain prescribed tests are necessary. The patient shall then be requested to sign the statement in Section II of SF-602.
25. DD-1141 (Record of Occupational Exposure to Ionizing Radiation). See Encl (1), pg.4-27.
- a. Requirements. The custodian of the medical records shall prepare and maintain as DD-1141 for each person occupationally exposed to ionizing radiation. Enter all exposures in rems.
 - b. Recording Procedures.
 - (1) Initial Determination of Accumulated Dose.
 - (a) In the initial preparation of DD-1141, obtain complete reports of previous exposure. For each period in which the individual was engaged in activities where occupational exposure was probable, and no record, or only an incomplete record of exposure during the period can be obtained, assume that an occupational exposure of 1.25 rems was incurred per quarter of each calendar year or fraction thereof.
 - (b) In cases where the nature of the radiation is unknown, assume gamma radiation.
 - (c) If an individual was exposed at more than one facility, calculate the cumulative exposures and record them in Items 7 through 12 as appropriate. Enter the sum of the whole body exposure in Item 13, and a statement regarding the sources of that information in Item 16, REMARKS.
 - (2) Current Record.
 - (a) Quarterly, make appropriate entries on each individual's DD-1141 from the exposure records received from the Public Health Service Contractor.
 - (b) Maintain separate DD-1141 to record exposures other than whole body, with appropriate descriptions under Item 16, REMARKS.
 - c. Completion Instructions.
 - (1) Item 1. Leave blank.
 - (2) Item: 2. Enter last name, first name, and middle initial. If the combination of last name and first name exceed 19 spaces, enter last name and initials only.
 - (3) Item 3. Enter SSN.
 - (4) Item: 4. Enter in not more than 10 spaces, rate, grade, title or position the individual is currently holding. Use standard service abbreviations: i.e., CAPT; HSCS; HSI; etc. Abbreviate civilian occupation titles as needed; i.e.,

Radiological Physicist to Rad Physic; Radiation Physiologist to Rd Physiol;
Electrical Welder to Elec Wldr; etc.

- (5) Item 5. Enter date of birth: i.e., 4 SEP 87.
 - (6) Item 6. Enter name of activity or unit.
 - (7) Items 7 & 8. "Period of Exposure." Enter the day, month, and year: i.e., 1 MAR 87.
 - (8) Items 9-12. "Dose This Period." Enter radiation dose received this period to three decimal places: i.e., 02.345rem. Use five digits including zeros as necessary for all entries.
 - (a) Item 9. Enter skin dose (soft) which includes low energy gamma and x-ray of less than 20 KVE effective energy and beta radiation. Total skin dose is the addition of columns 9 and 12.
 - (b) Item 10. Enter gamma and x-ray dose greater than 20 KVE effective energy in REM.
 - (c) Item 11. Enter neutron dose in REM.
 - (d) Item 12. Enter sum of items 10 and 11.
 - (9) Item 13. Add item 12 to previous item 13; enter total in item 13.
 - (10) Item 14. Enter permissible dose calculated from the age formula $5(N-18)$ REM, where N equals the present age in years.
 - (11) Item 15. Recorder certify entries by initial.
 - (12) Item 16. Enter other pertinent information such as known exposure from internally deposited radioactive material or from any external radioactive sources. Describe briefly any activity or assignment bearing a potential for exposure and estimate dose-time relationships, if feasible. If this form is used for other than whole body and skin of whole body, specify the use; i.e., hands and forearms, feet and ankles, thyroid, etc. When recorded dose is not obtained from film badge readings, specify whether estimates were obtained from pocket dosimeters, area or air monitoring, bioassay, etc.
26. [CG-4057 \(Chronological Record of Service\)](#). See Encl (1), pg 4-28.
- a. Purpose. Use this form:
 - (1) to maintain a chronological record of assignments for each active duty member of the Coast Guard;
 - (2) as a statement of agreement or disagreement with the assumption of fitness for duty upon separation from the Coast Guard; and
 - (3) to terminate the health record.
 - b. Chronological record of assignments. Prepare original only. Record the member's full name in all capitals, together with the Social Security Number. Make entries

each time a member leaves or returns from PCS, TAD, or hospitalization at a unit different than the one to which currently assigned.

- c. Agreement or disagreement with the assumption of fit for duty at the time of separation. Members not already in the physical disability evaluation system, who disagree with the assumption of fitness for duty at separation shall indicate on the reverse of form CG-4057. They shall then proceed as indicated in paragraph 3-B-5. of this Manual. Members who agree with the assumption shall check the box indicating agreement. This is a health services department responsibility when there is a health services department representative attached; otherwise it becomes a personnel action.
 - d. Terminating the health record. The reverse side of the form is also used to terminate a member's health record upon definite separation from active service. The date of termination is the effective date of separation. Make appropriate entries giving the reason for termination, the date of termination and the grade and signature of the responsible commissioned officer in the bottom portion of the form. Additionally, an entry, signed by the member whose health record is being terminated, acknowledging the receipt of a copy all available NAVMED 6150/20's, a copy of separation examination if done (either DD-2808 or SF-600 entry), a signed copy of the CG-4057, and the PHS-731 shall be made in the Remarks section of the CG-4057.
 - e. This form is also used to notify the individual of the possibility of certain disability benefit entitlements from the Department of Veterans Affairs after separation.
 - f. If either side of the CG-4057 is filled, the reverse side shall have a line drawn diagonally through it in red and a second CG-4057, marked "Supplement" at the top, started.
27. NAVMED 6150/2 (Special Duty Medical Abstract). See Encl (1), pg. 4-30.
- a. General. The purpose of the NAVMED 6150/2 is to provide a record of physical qualifications, special training, and periodic examinations of members designated for performing special duty, such as aviation and diving. The object of the special duty examination, and the instructions incident thereto, is to select only those individuals who are physically and mentally qualified for such special duty, and to remove from such status those members who may become temporarily or permanently unfit for such duty because of physical or mental defects. Also, in this connection, special money disbursements are often based upon the determination of a member's physical and mental qualifications or continued requalification for performing a special duty. Therefore, accuracy and content of information are essential in reporting information applicable to these categories.
 - b. Entries.
 - (1) Record entries upon completion of each physical examination and completion of designated special training. When a previously qualified member is suspended from special duty for physical reasons, enter the period of suspension and reason therefore on the NAVMED 6150/2.

- (2) The scope of the physical examination and technical training prescribed for these special categories often differs from the general service requirements; therefore, entries reporting results which pertain to these particular examinations or training involved shall be approved only by medical officers.

28. PHS-731 (International Certificate of Vaccination).

a. General.

- (1) Prepare PHS-731 for each member of the Coast Guard (for reserve personnel when ordered to Active Duty for Training). This form shall be carried only when performing international travel or when reporting for Active Duty for Training. When not required for either of the preceding reasons, the completed certificate shall be retained in the individual's health record. Appropriate entries shall be made on PHS-731 and SF-601 when immunizations are administered.
- (2) A reservist not on extended active duty who plans international travel either under official orders or privately, may request that the appropriate district commander (r) furnish a PHS-731 for this purpose. The reservist shall return the PHS-731 to the district commander (r) when travel is completed.
- (3) When properly completed and authenticated, the PHS-731 contains a valid certificate of immunization for international travel and quarantine purposes in accordance with World Health Organization Sanitary Regulations.
- (4) All military and nonmilitary personnel performing international travel under Coast Guard cognizance shall be immunized in accordance with Commandant Instruction 6230.4 (series) and shall have in their possession a properly completed and authenticated PHS-731.

b. Detailed Instructions.

- (1) Stamp or type the following address on the front of PHS-731:
Commandant (G-WK)
U. S. Coast Guard
2100 Second St., S.W.
Washington, DC 20593-0001
- (2) Enter data by hand, rubber stamp, or typewriter.
- (3) Enter the day, month, and year in the order named (i.e., 4 SEP 87).
- (4) Record the origin and batch number for yellow fever vaccine.
- (5) Entries for cholera and yellow fever must be authenticated by the Department of Defense Immunization Stamp and the actual signature of the medical officer. Other immunizations may be authenticated by initialing. Entries based on prior official records shall have the following statement added:
"Transcribed From Official Records."

- c. Remove the PHS-731 from the health record and give it to the individual upon separation from the Service.
29. **CG-5214 (Emergency Medical Treatment Report)**. See Encl (1), pg. 4-32.
- a. **Purpose**. CG-5214 provides a multiple copy record of all emergency medical care rendered by Coast Guard personnel outside of a clinic or sickbay. All care rendered by crews of Coast Guard emergency vehicles must be documented with a CG-5214.
 - (1) Part 1, Copy to Patient. This copy shall be placed in the patients' health record if available.
 - (2) Part 2, Copy to Receiving Unit. This copy shall be given to the hospital, clinic, or EMS crew assuming responsibility for patient care.
 - (3) Part 3, Copy to Triage Officer. In multi-casualty incidents, this copy shall be given to the triage officer to account for the patients' treatment priority and status. Otherwise, this copy shall be kept on file at the clinic or sickbay.
 - (4) Part 4, (hard copy) to Commandant (G-WKH-1). This copy shall be forwarded to Commandant (G-WKH-1) using the mailing label on the reverse side.
 - b. **Preparation and Submission of CG-5214**. The form provides an accurate account of the patient's injury or illness, and a detailed report of all treatments rendered en route to a receiving facility. If possible, the report should be completed during the transport phase. Detailed instructions for completing the CG-5214 are as follows:
 - (1) Victim Identification.
 - (a) Item 1: Name. Enter last, first, and middle initial.
 - (b) Item 2: Sex. Check one.
 - (c) Item 3: Estimated Age. Enter in years or months.
 - (2) Description of Incident.
 - (a) Item 4: Date. Enter date incident occurred.
 - (b) Item 5: Type of Incident. Check one and give pertinent details under "Nature of Emergency/Mechanism of Injury".
 - (c) Item 6: Time on Scene. Enter (using 24 hour clock).
 - (d) Item 7: Time of Incident. Enter (using 24 hour clock).
 - (e) Item 8: Location. Enter exact geographical area.
 - (3) Observation of Victim. Stick-Man figure: Place applicable injury letter code over injured area.
 - (4) Skin. Circle applicable number.
 - (5) Vital Signs. Note time observed (24 hour clock).
 - (6) Level of Consciousness. Check only one per time observed.

- (7) Pupils. Check only one per time observed.
- (8) Pulse. Place numerical value under rate and check appropriate space for quality.
- (9) Breathing. Place numerical value under rate and check appropriate space for quality.
- (10) Blood Pressure. Enter systolic and diastolic values under applicable time.
- (11) Temperature. Circle either oral or rectal and enter in numerical value.
- (12) Mast. Beside "Mast BP" enter blood pressure values. Circle applicable compartments inflated.
- (13) Triage Information. Circle one of the following:
 - (a) Priority I: Patients with airway and/or breathing problems, cardiac arrest, uncontrolled bleeding or controlled bleeding with symptoms of shock, severe head or abdominal injuries, and severe medical problems to include possible heart attack, severe burns, and severe poisonings.
 - (b) Priority II: Patients with less serious burns, multiple fractures, potential C-Spine injuries without shock, or medical conditions of a less serious note.
 - (c) Priority III: Patients with obvious minor injuries or patients who are obviously dead or mortally wounded.
- (14) Medications. List any medications the patient is currently taking.
- (15) Allergies. List any known allergies for the patient.
- (16) Medications Administered. Note the time, dosage, and route of administration for any medications administered to the patient.
- (17) Rescuer Information.
 - (a) Item 10: Name. Enter last, first, and middle initial.
 - (b) Item 11: Level. Circle appropriate certification level.
 - (c) Item 12: Unit. Rescuer's assigned unit.
 - (d) Item 13: OPFAC#. Enter.
 - (e) Item 14: rescue Vehicle. Identity of the responding vehicle, vessel, or aircraft.
 - (f) Item 15: Receiving Unit. Hospital, EMS vehicle, or clinic assuming responsibility for patient care.
 - (g) Time Patient Transferred. Enter (24 hour clock).

30. [DD877 \(Request for Medical/Dental Records or Information\)](#). See Encl (1), pg. 4-33.
- Purpose. The DD 877 is a self-carboning triplicate form that is used to forward health and clinical records between clinics and units as well as to request records from clinics, units, or MTFs.
 - General. This form shall be initiated and included with health and clinical records as directed in Chapter 4-A-6. And 4-D-7. Of this Manual
 - Detailed Instruction.
 - (1) Each DD877 must have all boxes completed.
 - (2) In all instances when a DD877 is initiated, remarks concerning the reason for sending the record, the name of the gaining unit for the member/ sponsor and a request for action will be included on the form. When preparing a DD877 for a record to be forwarded, place the following in section 9., REMARKS: "Health {clinical} record for this member (family member) is forwarded to you for appropriate filing. Member (sponsor) assigned to (insert gaining unit name)."
 - (3) For members entering the inactive reserve, enter the following in section 9, remarks: "**member entering inactive reserve in your district**. Per Medical Manual, COMDTINST M6000.1(series), Chapter 4-B-4.b.,this health record is forwarded for appropriate action."
 - (4) A copy of the DD877 will be retained at the unit sending the record for 6 months after the record is mailed, then may be discarded.
31. [CG-5447 \(History and Report of OMSEP Examination\)](#) See Encl (1), pg 53.
- The CG 5447 is used to biennially update the Occupational Medical Surveillance and Evaluation Program. Demographic and identification information is vital to maintaining the database. CG 5447 will allow better tracking of personnel currently enrolled in OMSEP. Complete the form as follows:
 - Item 1: Last Name**. Last Name - First Name - Middle Name. Record the surname in all capital letters. Record the given name(s) in full without abbreviation. If the individual's first or middle name consists only of an initial, enclose each initial in quotation marks (i.e., MANUEL, Thomas "W"). If the individual has no middle name, enter the letter "(n)" in parenthesis [i.e., TARVIN, Laurie (n)]. Designations, such as, "Jr." or "II" shall appear after the middle name or initial. In the absence of a middle name or initial, these designations shall appear after the "(n)".
 - Item 2: Grade/Rate/Rank**. Use official abbreviation of the current grade or rate, branch of service, class and status; i.e., regular, reserve, or retired, and if active or inactive. Example: HSCS, USCG; SN, USCG (TEMPRET); ETCM, USCG (RET). If not a service member, enter "civilian."
 - Item 3: SSN**. Enter the Social Security Number.

- (4) **Item 4: Date of Exam.** Enter date in format e.g. 04Sept03.
- (5) **Item 5: Home Address.** Enter home address in full (where examinee presently resides).
- (6) **Item 6: Work/duty phone.** Enter phone number beginning with area code. Include extension (if any), e.g., (xxx)-xxx-xxxx, ext xxxx.
- (7) **Item 7: Unit Name and location.** Enter unit, ship or station to where examinee is assigned.
- (8) **Item 8: Home phone.** Enter phone number beginning with area code. Include extension (if any), e.g., (xxx)-xxx-xxxx, ext xxxx.
- (9) **Item 9: Unit OPFAC#.** Enter OPFAC number of unit to which examinee is attached.
- (10) **Item 10: Unit Zip Code:** Enter unit's 5-digit zip code, e.g., 20593.
- (11) **Item 11: Date of Birth & Age.** Enter date followed by age in parentheses, e.g., 3Mar48 (54).
- (12) **Item 12: Sex.** Enter appropriate letter: (M) male or (F) female.
- (13) **Item 13: Race or Ethnicity.** Enter a one character designator to identify the examinee's racial or ethnic group:
 - (a) 1-Black (Negro);
 - (b) 2-Hispanic (includes persons of Mexican, Puerto Rican, Cuban, Central and South American, or other Spanish origin or culture regardless of race);
 - (c) 3-American Indian (including Alaskan Natives);
 - (d) 4-Asian (including Pacific Islanders); or
 - (e) 5-All others (e.g., White/Caucasian, etc.)
- (14) **Item 14: Occupational or usual duties.** Describe all primary duties, positions or billet assignments, (e.g. inspector, electrician, ASM).
- (15) **Item 15: Examining Facility Name & Location.** For civilian or contract physician, enter the full name and address. For a USMTF, enter only the facility name and the city and state in which located.
- (16) **Item 16. Purpose of Examination.** Mark appropriate box. If uncertain ask for assistance.
- (17) **Item 17. Years in Occupation.** List number of years in present position or job title.
- (18) **Item 18-24. (Part 1-Section 1-Occupational History).** Mark appropriate box Yes (Y) or No (N) as indicated.

- (19) **Item 25. (Part 1-Section 1-Occupational History).** Explain all Yes (Y) answers to question 18-24 above.
- (20) **Item 26. (Part 1-Section II-Family History).** Mark appropriate Yes (Y) or No (N) as indicated.
- (21) **Item 27. (Part 1-Section III-Social History).** Mark appropriate box Yes (Y) or No (N) as indicated. Where indicated, please enter the number that best approximates the amount of tobacco products consumed/used by the examinee. If examinee does not consume tobacco products but is frequently exposed to second hand smoke (home; social group) please describe in Item 33 below.
- (22) **Item 28. (Part 1-Section III-Social History).** Mark appropriate box Yes (Y) or No (N) as indicated. Where indicated, please enter the number that best approximates the amount of alcoholic beverages consumed/used by the examinee.
- (23) **Item 29. (Part 1-Section III-Social History).** Mark appropriate box Yes (Y) or No (N) as indicated. Explain all YES answers.
- (24) **Item 30 (Part 1-Section IV – Personal Health History).** Mark appropriate box Yes (Y) or No (N) as indicated.
- (25) **Item 31. (Part 1-Section IV – Personal Health History).** Mark the one box that best describes the examinees present health status.
- (26) **Item 32. (Part 1-Section IV – Personal Health History).** Mark appropriate box Yes (Y) or No (N) as indicated.
- (27) **Item 33. (Part 1-Section IV – Personal Health History).** Enter comments and explain all Yes (Y) responses to questions 27-32.
- (28) **Examinee must sign and date form.**
- (29) **Item 34. (Part 1-Occupational Exposure History).**
- (a) Column 1 - In chronological order list all known/documented exposures, including those occurring in prior employments.
 - (b) Column 2 - Enter the date of the known exposure, e.g. year/day/month.
 - (c) Column 3 - Enter the name of the place where exposure is known to have occurred.
 - (d) Column 4 – List the type (if any) for protective equipment in use during the documented exposure
- (30) **Examinee must sign and date form.**
- (31) **Part 2 - Medical Officer Section.**
- (a) **Item 1-4.** Same as Part 1 Items 1-4 first page. Provider must enter.

- (b) **Item 5. Examining Facility Name & Location.** For civilian or contract physician, enter the full name and address. For a USMTF, enter only the facility name and the city and state in which located.
- (c) **Item 6. Enter the phone number of facility/medical provider** performing the examination. Include area code and seven-digit number and extension, if indicated e.g. (xxx) xxx-xxxx extension xxx.
- (d) **Item 7. Surveillance Protocols.** Mark the indicated box for each of the examinee's documented exposure protocols for which an examination was performed. For a *separation/termination examination* make sure to include ALL documented exposure protocols (past and present) for which surveillance was performed.
- (e) **Item 8. Occupational related diagnosis.** List ALL occupationally related diagnosis, e.g., asbestosis; leukemia, mesothelioma).
- (f) **Item 9. Respirator Wear.** Mark appropriate box.
- (g) **Item 10. Conclusions.** Mark appropriate box.
- (h) **Item 11. Next OMSEP Examination.** For a regular schedule exam at the default time mark the space for "12 months". You may enter any specific time interval (of less than 12 months) under space marked "Other".
- (i) **Item 12.** Enter appropriate date when examinee was notified of examination results. This is a **mandatory** requirement.
- (j) **Item 13.** Provider should utilize this space to expand on all aforementioned diagnosis, to provide recommendations on follow-up care, and advise on future testing or procedures.
- (k) **Medical provider must print name, sign and date form in space provided.**

32. **CG-5447A (Periodic History and Report of OMSEP Examination).** See Encl (1), pg 57.

- (1) The CG-5447 A Periodic History and Report of OMSEP Examination is to be used for all scheduled periodic examinations. The member should review the last/previous OMSEP examination prior to completing this form.
- (2) **Items 1-10.** Follow the same guidelines for part 1, CG-5447, Chapter 4-B-30-a.(1)-(7).
- (3) **Item 11.** Follow the same guidelines in Item 15 part 1, CG-5447, Chapter 4-B-30-a.(15).
- (4) **Item 12. Last OMSEP Exam.** Enter date of last OMSEP Initial/periodic or separation examination on record.

Item 13. Present Exposure Protocols. Enter all documented exposure protocols for which examinations are scheduled.

- (5) Any changes since the **last** examination should be listed and describe in the “comments” area indicated for each of the particular sections. If no changes have occurred the member need only check the “no change “ box, as indicated, for each of the particular sections.

Section 1- Occupational History

Section 2- Family History

Section 3- Social History

Section 4- Personal Health History

Occupational Exposure

- (6) **Health Care Provider Review.** The medical officer is responsible for reviewing the completed CG-5447A and accompanying laboratory and radiological study results (if any), as well as making any final recommendations. The medical officer **MUST** enter all appropriate comments in the “recommendations” space, including any additional studies, follow-up examinations or consultations. The medical provider **MUST** also initial the appropriate boxes indicating the review of any laboratory studies or radiological procedures performed as part of this examination.
- (7) The medical officer **MUST** provide name and signature as well as date the CG-5447A (in the spaces provided) indicating the examinee was notified of any results and recommendations. When finalized the CG-5447A is to be placed into the member’s medical record.
- (8) **Note:** If no changes have been reported by the examinee since the last examination and laboratory studies or radiological procedures (if any) are all within normal parameters, the designated health services technician (HST) may review and initial (sign and stamp) the completed CG-5447A **after** discussing the results with the cognizant medical officer and obtaining approval. The HST must make the following notation: “discussed and approved by medical officer” below the signature block. This allowance is intended primarily for situations where the cognizant medical officer is geographically separated and travel to/from the units negatively impacts unit operations.

33. **DD-2870 Authorization for Disclosure of Medical or Dental Information.**

- (1) In order to use or disclose patient health information for purposes beyond the treatment, payment and health care operations and other purposes described in the MHS Notice of Privacy Practices, written authorization from the patient must be obtained on form DD-2870.

34. **DD-2871 Request to Restrict Medical or Dental Information.**

Individuals have the right to request restrictions on the use or disclosure of their health information. Requests must be made in writing on form DD-2871. Requests for restriction may be denied upon review by the clinic HIPAA Privacy/Security Official, or the Coast Guard HIPAA Privacy/Security Official.

Section C - Dental Record Forms.

1. [CG-3443-2 \(Dental Record Cover\)](#). See Encl (1), pg. 4-34.
 - a. Open a CG-3443-2 for each individual upon arrival at a training center or initial entry into the Coast Guard or Coast Guard Reserve. When an individual on the retired list returns to active duty, submit a request for a copy of the closed out dental record to Commandant (G-PIM). Whenever the original record is lost or destroyed, a new dental record shall be opened immediately. The dental record shall be kept in the Health Record Cover (CG-3443) of each individual.
 - b. All dental forms and radiographs will be contained in the Dental Record.
 - c. Detailed Instructions.

- (1) Surname. Record the surname in all capital letters.

DOE

SURNAME

- (2) Given name(s). Record in full without abbreviation. If the individual has no middle name or initial then record the lower case letter "n" in parentheses (n). If the individual has only a middle initial(s), record each initial in quotation marks. When "Jr." or "II" or other similar designations are used, they shall appear after the middle name or initial.

DOE JANE ANN

SURNAME First Name Middle Name

- (3) Social Security Number (SSN). Enter Social Security Number.
- (4) Date of Birth. Enter day, month (abbreviated JAN, FEB, MAR, etc.), and the year: i.e., 4 SEP 49.
- (5) Change in Grade or Rate. Enter as they occur.
- (6) Blood Type. Enter the individual's blood type in the appropriate box. If not known, perform a blood type test.
- (7) RH Factor. Enter the individual's RH factor in the appropriate box. If not known, perform an RH factor test.
- (8) Drug Sensitivity Sticker. When required, affix the Drug Sensitivity Sticker (CG-5266) to the lower left corner of the front of the Dental Record Cover. Do not cover other identification data. [See Encl \(1\) pg. 4-34.](#)
- (9) Dental Radiographs.

- (a) **Dental Bitewing Radiograph Storage.** Bitewing radiographs shall be stored in the standard stock 5-year x-ray card (FSC# 6525-00-142-8732). This shall replace the single bitewing x-ray card (FSC# 6525-00-817-2364). X-ray film is mounted in the x-ray card with the raised dot side of the film on the **front** side of the card.
2. **NAVMED 6600/3 (Dental Health Questionnaire).** See Encl (1), pg. 4-35.
 - a. **General.** CG-5605 will help the dental officer detect any present or past health problem (i.e., positive Human Immunodeficiency Virus (HIV)) that might interfere with definitive dental treatment. All positive answers from the health history section must be followed up by the dental officer for impact on health care and so annotated on the CG-5605 and the SF-603A.
 - b. **Detailed Instructions.** Insert the Dental Health Questionnaire as the first page of the dental record. Patients shall fill out a new Dental Health Questionnaire at least annually, or when information changes. Maintain the two most recent forms in the dental record with the current CG-5605 on top.
 - (1) **Chief Complaint.** Have the patient enter the problem they are presently having.
 - (2) **Check and Sign.** Have the patient enter yes/no in each box of the history. The signature indicates the authenticity of the history.
 - (3) **Summary of Pertinent Findings.** Include baseline BP reading.
3. **SF-603 (Dental Record).** See Encl (1), pg. 4-36.
 - a. **General.** The Dental Record is a continuous history and must contain accurate and complete entries of dental examinations and treatments. Each entry shall clearly indicate the name of the dental officer conducting the examination and/or rendering the treatment. Dental hygienists or other auxiliary personnel providing care shall also follow this requirement. Each dental officer is personally responsible for ensuring that all entries are properly recorded.
 - b. **Numerical Classification for Record Purposes.** Chart markings have been standardized so that dental conditions, treatments needed, and treatments completed may be readily identified. This facilitates efficient continuity of treatments and may establish identification in certain circumstances.
 - (1) Use the following numbering system for permanent dentition starting with the maxillary right third permanent molar as tooth #1:

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

- (2) Use the following numbering system for deciduous dentition starting with the maxillary right second deciduous molar as tooth A:

A	B	C	D	E	F	G	H	I	J
T	S	R	Q	P	O	N	M	L	K

- (3) Indicate a supernumerary tooth by placing "s" in the location of the supernumerary tooth and in the remarks section enter a statement that the examinee has a supernumerary tooth.
- (4) Indicate deciduous and supernumerary teeth on the SF-603 in SECTION I, Part 5 (Diseases, Abnormalities, and Radiographs) and enter a statement in the remarks section of Section 5.

c. Detailed Instructions.

SECTION I. DENTAL EXAMINATION

- (1) Purpose of Examination. To assess the oral health status of cadets, officer candidates and enlisted recruits upon initial entry into the Coast Guard, and to provide periodic (but at least annual) examinations of active duty personnel. Enter an "X" in the appropriate box. Mark the "Initial" box for the dental examination made upon entrance into the Coast Guard. All other examinations fall under the "Other" category and shall be identified: i.e., "Academy", "Reenlistment", etc.
- (2) Type of Examination. Enter an "X" in the proper box of item 2, "Type of Exam."
- (a) Type 1, Comprehensive Examination. Comprehensive hard and soft tissue examination, which shall include: oral cancer screening examination; mouth-mirror, explorer, and periodontal probe examination; adequate natural or artificial illumination; panoramic or full-mouth periapical, and posterior bitewing radiographs as required; blood pressure recording; and when indicated, percussive, thermal, and electrical tests, transillumination, and study models. Included are lengthy clinical evaluations required to establish a complex total treatment plan. For example, treatment planning for full mouth reconstruction, determining differential diagnosis of a patient's chief complaint, or lengthy history taking relative to determining a diagnosis. Use S.O.A.P. format to record the results of a Type 1 examination.
- (b) Type 2, Oral Examination (annual or periodic). Hard and soft tissue examination, which shall include: oral cancer screening examination; mouth mirror and explorer examination with adequate natural or artificial illumination; periodontal screening; appropriate panoramic or intraoral radiographs as indicated by the clinical examination; and blood pressure recording. An appropriate treatment plan shall be recorded. This type is the routine examination, which is normally performed one time per treatment regimen per patient, unless circumstances warrant another

complete examination. Use S.O.A.P. format to record the results of Type 2 examination.

- (c) Type 3, Other Examination. Diagnostic procedure as appropriate for: consultations between staff; observation where no formal consult is prepared; certain categories of physical examination; and emergency oral examination for evaluation of pain, infection, trauma, or defective restorations **and follow-up exams for previously rendered treatment.**
 - (d) Type 4, Screening Evaluation. Mouth mirror and explorer or tongue depressor examination with available illumination. This includes the initial dental processing of candidates without necessarily being examined by a dentist, or other dental screening procedures.
 - (e) If not specified by this Manual, it shall be the professional responsibility of the dental officer to determine the type of examination which is appropriate for each patient. However, Type 3 and Type 4 examinations are not adequate to definitively evaluate the oral health status of patients. When the dental officer determines that a comprehensive periodontal examination is to be accomplished, use the Navy Periodontal Chart, NAVMED 6660/2 (3-90).
- (3) `Dental Classification of Individuals. Dental classifications are used to designate the health status and the urgency or priority of treatment needs for active duty personnel. Use the following guidelines and criteria for the classification of patients. When a criterion for a specific condition is not listed, the dental officer shall evaluate the prognosis for a dental emergency and assign the appropriate classification.
- (a) **Class I (Oral Health):** Patients with a current dental examination, who do not require dental treatment or reevaluation. Class 1 patients are worldwide deployable.
 - (b) **Class II:** Patients with a current dental examination, who require non-urgent dental treatment or reevaluation for oral conditions, which are unlikely to result in dental emergencies within 12 months. Class 2 are worldwide deployable. Patients in dental class 2 may exhibit the following:
 - 1 Treatment or follow-up indicated for dental caries or minor defective restorations that can be maintained by the patient.
 - 2 Interim restorations or prostheses that can be maintained for a 12-month period. This includes teeth that have been restored with permanent restorative materials for which protective cuspal coverage is indicated.
 - 3 Edentulous areas requiring prostheses but not on an immediate basis.
 - 4 Periodontium that:

- a requires oral prophylaxis.
 - b Requires maintenance therapy.
 - c Requires treatment for slight to moderate periodontitis and stable cases of more advanced periodontitis.
 - d requires removal of supragingival or mild to moderate subgingival calculus.
 - 5 Unerupted, partially erupted, or malposed teeth that are without historical, clinical, or radiographic signs or symptoms of pathosis, but which are recommended for prophylactic removal.
 - 6 Active orthodontic treatment. The provider should consider placing the patient in passive appliances for deployment up to six months. For longer periods of deployment, the provider should consider removing active appliances and placing the patient in passive retention.
 - 7 Temporomandibular disorder patients in remission. The provider anticipates patient can perform duties while deployed without ongoing care and any medications or appliances required for maintenance will not interfere with duties.
- (c) **Class III:** Patients who require urgent or emergent dental treatment. Class 3 patients normally are not considered to be worldwide deployable.
- 1 Treatment or follow-up indicated for dental caries, symptomatic tooth fracture or defective restorations that cannot be maintained by the patient.
 - 2 Interim restorations or prostheses that cannot be maintained for a 12-month period.
 - 3 Patients requiring treatment for the following periodontal conditions that may result in dental emergencies within the next 12 months.
 - a Acute gingivitis or pericoronitis.
 - b Active progressive moderate or advanced periodontitis.
 - c Periodontal abscess.
 - d Progressive mucogingival condition.
 - e Periodontal manifestations of systemic disease or hormonal disturbances.
 - f Heavy subgingival calculus.

- 4 Edentulous areas or teeth requiring immediate prosthodontic treatment for adequate mastication or communication, or acceptable esthetics.
 - 5 Unerupted, partially erupted, or malposed teeth with historical, clinical or radiographic signs or symptoms of pathosis that are recommended for removal.
 - 6 Chronic oral infections or other pathologic lesions including:
 - a. Pulpal, periapical, or resorptive pathology requiring treatment.
 - b. Lesions requiring biopsy or awaiting biopsy report.
 - 7 Emergency situations requiring therapy to relieve pain, treat trauma, treat acute oral infections, or provide timely follow-up care (e.g., drain or suture removal) until resolved.
 - 8 Acute Temporomandibular disorders requiring active treatment that may interfere with duties.
- (d) **Class IV:** Patients who require periodic dental examinations or patients with unknown dental classifications. Class 4 patients normally are not considered to be worldwide deployable.
- (4) **Priority of Dental Treatment.** To further indicate priority of treatment within a class, the following groupings shall be used when necessary (listed in order of decreasing priority).
- (a) Group 1. Coast Guard active duty personnel in receipt of orders to sea, overseas, or combat duty.
 - (b) Group 2. Coast Guard active duty personnel upon return from sea, overseas, or combat duty.
 - (c) Group 3. Other Coast Guard personnel.
 - (d) Group 4. Active duty personnel of other Services assigned to duty with the Coast Guard.
 - (e) Group 5. Active duty personnel of other Services.
 - (f) Missing Teeth and Existing Restorations.
 - (g) Markings shall be made on examination chart as follows:
 - 1 Missing Teeth. Draw a large "X" on the root(s) of each tooth that is not visible in the mouth.
 - 2 Edentulous Mouth. Inscribe crossing lines, one extending from the maxillary right third molar to the mandibular left third molar and the other from the maxillary left third molar to the mandibular right third molar.

- 3 Edentulous Arch. Make crossing lines, each running from the uppermost aspect of one third molar to the lowest aspect of the third molar on the opposite side.
 - 4 Amalgam Restorations. In the diagram of the tooth, draw an outline of the restoration showing size, location, and shape, and block solidly.
 - 5 Nonmetallic Permanent Restorations (**includes ceramics and resins**). In the diagram of the tooth, draw an outline of the restoration showing size, location, and shape.
 - 6 Gold Restorations. Outline and inscribe horizontal lines within the outline.
 - 7 Combination Restorations. Outline showing overall size, location, and shape; partition and junction materials used and indicate each, as in "4." above.
 - 8 Porcelain **and acrylic** Post Crowns. Outline the crown and approximate size and position of the post(s).
 - 9 Porcelain Veneers. Outline each aspect.
 - 10 Acrylic Resin Jacket Crowns. Outline each aspect.
 - 11 Fixed Bridges. Outline each, showing overall size, location, teeth involved and shape by the inscription of diagonal lines in abutments and pontics.
 - 12 Removable Appliances. Place an "X" through the missing tooth, place a line over replaced teeth and describe briefly in "Remarks."
 - 13 Root Canal Fillings. Outline canal filled and black in solidly.
 - 14 Apicoectomy. Draw a small triangle apex of the root of the tooth involved, the base line to show the approximate level of root amputation.
 - 15 Drifted Teeth. Draw an arrow from the designating number of the tooth that has moved; the point of the arrow to indicate the approximate position to which it has drifted. Under "Remarks" note the relationship to the drifted tooth in respect to occlusion.
- (h) If an individual is appointed or enlisted with dental defects which have been waived, the defects shall be described fully in the dental record under "Remarks" (Section I).
- (i) The examining dental officer shall sign, date, and record the place of examination where indicated.

(5) Diseases, Abnormalities, and Radiographs.

- (a) Markings on the examination chart of Diseases, Abnormalities, and Radiographs shall be made as follows:
 - 1 Caries. In the diagram of the tooth affected, draw an outline of the carious portion, showing size, location and shape, and block in solidly.
 - 2 Defective Restoration. Outline and block in solidly the restoration involved.
 - 3 Impacted Teeth. Outline all aspects of each impacted tooth with a single oval. Indicate the axis of the tooth by an arrow pointing in the direction of the crown.
 - 4 Abscess. Outline approximate size, form, and location.
 - 5 Cyst. Outline the approximate form and size in relative position of the dental chart.
 - 6 Periodontal Disease. Inscribe a horizontal continuous line on the external aspect of root(s) involved in a position approximating the extent of gingival recession or the clinical depth of the pocket. If known, indicate the position of the alveolar crest by a second continuous line in relative position to the line indicating the gingival tissue level.
 - 7 Extraction Needed. Draw two parallel vertical lines through all aspects of the tooth involved.
 - 8 Fractured Tooth Root. Indicate fracture with a zigzag line on outline of tooth root.
- (b) A statement regarding hypersensitivity to any other drug known to the person for whom a Dental Record is prepared shall be entered under "Remarks." (Example: HYPERSENSITIVITY TO PROCAINE)
- (c) Complete items A through E.
- (d) The examining dental officer shall sign, date, and record the place of examination where indicated.
- (e) NOTE: Section I, Subsections 4 and 5 of SF 603 are used to record findings of initial and replacement examinations. These charts shall not be altered thereafter.

SECTION II. PATIENT DATA

- (1) Patient Data. Complete items 6 through 14 as indicated.

SECTION III. ATTENDANCE RECORD

- (1) Restorations and Treatments (Completed during service) (Item 15).
 - (a) Record restorations or treatments provided a patient after the initiation of a Dental Record on the chart "Restorations and Treatments" of Section III, in accordance with the following:
 - 1 Carious Teeth Restored. In the diagram of the tooth involved, draw an outline of the restoration showing size, location and shape, and indicate the material used. Amalgam restorations would be outlined and blocked in, composite resin restorations outlined only, etc.
 - 2 Extractions. Draw a large "X" on the root(s) of each tooth extracted.
 - 3 Root Canal Fillings. Outline each canal filled on the diagram of the root(s) of the tooth involved and block it in solidly.
 - 4 Apicoectomy. Draw a small triangle on the root of the tooth involved, apex away from the crown, the base line to show the approximate level of tooth amputation.
 - 5 Bridge and Crowns. Outline and fill in as specified above.
 - 6 Removable Appliances. Place a line over numbers of replaced teeth and give a brief description under "Remarks."
 - 7 Unrecorded Operations and Conditions. Operations performed by other than Coast Guard dental officers subsequent to the original examination will be indicated by the dental officer discovering the condition just as if they had been done by a Coast Guard dental officer. Make appropriate entries indicating the nature of the treatment and adding the abbreviation "CIV" or other abbreviation as the case may be. The date entered will be the date of the discovery.
 - 8 Other. Similarly, note operations known to have been performed by Coast Guard dental officers whose identity is not recorded, except use the abbreviation "CGDO." The date entered shall be the date the operation is discovered. Account for teeth which are shown as missing in the chart, Missing Teeth and Existing Restorations, and which have erupted subsequently, by an entry in the following manner: "1 and 32," eruption noted, date, and signature of dental officer making the notation. Record other conditions of comparable importance in a similar manner.
 - (b) Record a series of treatments for a specific condition not producing lasting changes in dental characteristics by entering of initial and final treatment dates (i.e., POT daily 1 AUG 87 thru 5 AUG 87 or Vin Tr. twice daily 1 AUG 87 thru 10 AUG 87).

- (c) Authenticate each entry in this record by a written entry in the spaces provided under "Services Rendered."
- (2) Subsequent Disease and Abnormalities (Item 16). Chart subsequent conditions, in pencil only, using the instructions in Chapter 4-C.3.(6). Once treatment is completed and documented in item 17, erase pencil entry in item 16 and permanently transfer in ink to item 15 (Restorations and Treatments).
- (3) Services Rendered (Item 17). The accuracy and thoroughness in recording patient histories and treatment progress notes are essential elements in the diagnosis and treatment of the dental patient. In addition to the conventional listing of the tooth number and procedure, **all dental materials used intraorally shall be identified.** Use trade names where possible. This includes, but is not limited to; bases and liners, metallic and nonmetallic restorative materials, denture frameworks and bases, impression materials, medicaments, and anesthesia. Record prescribed medications.
- (a) Standard S.O.A.P. format. The S.O.A.P. format shall be used to document all sickcall and emergency dental treatments, to document Type 1 and Type 2 examinations, and to record the results of the examination of patients in preparation for comprehensive treatment planning. S.O.A.P. format is not required to document ongoing delivery of treatment, which has been previously planned. All entries are to be on the SF-603/603-A, item 17. The S.O.A.P. format uses a problem-oriented record as a tool in management of patient care. The acronym is derived from the first letter of the first four record statements as follows:
- 1 **"S" Subjective data.** This data includes the reason for the visit to the dental clinic, and if appropriate, a statement of the problem (chief complaint "in the words of the patient") and the qualitative and quantitative description of the symptoms appropriate to the problem.
 - 2 **"O" Objective data.** A record of the type of examination and the diagnostic aids, including the ordering of radiographs, and the actual clinical findings, x-ray results, or laboratory findings appropriate to the problem. This is to include all the provider's findings such as carious teeth, inflammation, periodontal status, pocket depths, blood pressure measurement, etc.
 - 3 **"A" Assessment.** This portion is the assessment of the subjective data, objective data, and the problem statement which leads the provider to a diagnosis, e.g., "needs" (existing conditions or pathoses).

4 **"P" Plan.** This is the plan of treatment to correct or alleviate the stated problems or needs, irrespective of the treatment capability of the dental treatment facility. Include recommended treatment and, as appropriate, possible complications, alternative treatment, and prognosis with and without intervention. Include consultations, a record of the specific treatment performed, pre- and postoperative instructions, prescriptions, and any deviations from the original treatment plan.

- (b) The following classification of tooth surfaces are listed in order of precedence and shall be used in connection with recording restorations of defective teeth:

Surface	Designation
Facial (Labial) (Anterior teeth)	F
Buccal (Posterior teeth)	B
Lingual	L
Occlusal (Posterior teeth)	O
Mesial	M
Distal	D
Incisal (Anterior teeth)	I

- (c) Use combinations of designators to identify and locate caries, operations, or restorations in the teeth involved; for example, 8-MID would refer to the mesial, incisal, and distal aspects of the left mandibular cuspid; 30-MODF, the mesial, occlusal, distal, and facial aspects of a right mandibular first molar.

Surface	Designation
Mesial-Occlusal	MO
Distal-Occlusal	DO
Mesial-Incisal	MI
Distal-Incisal	DI
Occlusal-Facial	OF
Occlusal-Lingual	OL
Incisal-Facial	IF
Incisal-Lingual	IL
Mesial-Occlusal-Distal	MOD
Mesial-Occlusal-Facial	MOF

Mesial-Occlusal-Lingual	MOL
Mesial-Incisal-Distal	MID
Mesial-Incisal-Facial	MIF
Mesial-Incisal-Lingual	MIL
Distal-Occlusal-Facial	DOF
Distal-Occlusal-Lingual	DOL
Mesial-Occlusal-Distal-Facial	MODF
Mesial-Incisal-Distal-Facial	MIDF
Mesial-Occlusal-Distal-Facial-Lingual	MODFL
Mesial-Incisal-Distal-Facial-Lingual	MIDFL

- (d) The use of abbreviations is not mandatory but is desirable for purposes of brevity in view of the limited space available in the dental record for recording services rendered. Whenever there is a possibility of misinterpretation due to the use of abbreviations, dental operations shall be written in full. When abbreviations are used, they shall conform to the following:

Operation, Condition, or Treatment	Abbreviation
Abrasion	Abr.
Abscess	Abs.
Acrylic	Acr.
Adjust (ed)(ment)	Adj.
Amalgam	Am.
Anesthesia	Anes.
Apicectomy	Apico.
Bridge (denotes fixed unless otherwise noted)	Br.
Calcium Hydroxide	CaOH
Calculus	Calc.
Cavity Varnish	C.Var.
Cement	Cem.
Complete Denture (full unless otherwise noted)	CD.
Composite Resins	Comp. Res.
Crown	Cr.

Deciduous	Decid.
Defective	Def.
Drain.	Drn.
Equilibrate (action)	Equil.
Eugenol	Eug.
Extraction	Ext.
Fluoride	Fl.
Fracture(s)	Frac.
General	Gen.
Gingival (itis) (state type in parenthesis).	Ging.
Gutta percha	G.P.
Impacted (ion)	Imp.
Impression	Impr.
Maxillary	Max.
Mandibular	Mand.
Periapical	PA.
Pericoronitis	P-Cor.
Periodontitis	Perio.
Porcelain	Porc.
Post Operative Instructions Given	POIG.
Post Operative Treatment	POT.
Prepared (ation)	Prep.
Prophylaxis	Prophy.
Reappoint (ment)	Reappt.
Recement (ed)	Recem.
Reduce (d)	Red.
Removable Partial Denture	RPD.
Sedative (ation)	Sed.
Sequestrum	Seq.
Surgical	Surg.
Suture (s)(d)	Su.

Treatment (ed)

Tx.

Zinc Chloride

ZnCl.

- (4) Space is provided in the lower right margin under Section III for the patient's name which is for convenience in filing in the dental record. Record the last name in capital letters. Do not abbreviate any part of the name.

4. SF-603-A (Dental Continuation).

- a. General. Use a SF-603-A whenever the original SF-603 becomes filled or when the record cannot be satisfactorily brought up-to-date by entries on the appropriate chart.
- b. Detailed Instructions.
- (1) Enter individual's name and SSN in the space provided on the right margin of both the front and backside of the form.
- (2) Number the continuation sheet in the upper right corner following the phrase "DENTAL-Continuation." Thus, the earliest SF-603-A is labeled "DENTAL-Continuation #1" and subsequent sheets are labeled "DENTAL-Continuation #2", "DENTAL-Continuation #3", etc.
- (3) File the SF-603-A forms on top of the SF-603 form in reverse chronological order, i.e., the most recent on top.

5. SF-513, Consultation Sheet.

- a. Purpose. SF-513 shall be used whenever a patient is referred to another facility for evaluation or treatment.
- b. Detailed Instructions. Complete the form as detailed in paragraph 4-B-14.b.

6. Lost Dental Records.

- a. Forward "stray" dental records, disposition of which cannot be determined, to Commandant CGPC-adm-3 with a letter of explanation.
- b. When a Dental Record is missing, prepare a new record. Prominently mark the Dental Record Cover (CG-3443-2) and the Health Record, Dental (SF-603) "REPLACEMENT." Request the old Dental Record from the individual's last unit or Commandant CGPC-adm-3.
- c. In case a lost Dental Record is recovered, **incorporate the replacement record into the original record.**

7. Special Dental Records Entries. When dental treatment is refused, make an appropriate entry on the SF-603/603-A, **signed by both the dental officer and patient.**

8. Dental Examination Requirements.

- a. Any peculiarities or deviations from normal are particularly valuable for identification purposes and shall be recorded on SF-603 under "Remarks." Abnormalities such as erosion, mottled enamel, hypoplasia, rotation, irregularity of

alignment and malocclusion of teeth, presence of supernumerary teeth, denticles, Hutchinson's incisors, fractures of enamel or teeth, abnormal interdental spaces, mucosal pigmentation, leukoplakia, diastema, hypertrophied frenum labium, torus palatinus and torus mandibularis, **tattoos, piercings**, embedded foreign bodies and descriptions of unusual restorations or appliances are, when noted, especially useful in this connection. Malocclusion shall be simply and clearly described. Dentures and other removable dental appliances shall also be described under "Remarks".

- b. When all teeth are present, and free of caries or restorations, take special effort to discover and record any abnormalities, however slight. If no caries, restorations, or abnormalities are found, make an entry to that effect on SF-603 under "Remarks."
 - c. Inquire about the patients' tobacco use during routine dental examinations and document. Advise users of the health risks associated with tobacco use, the benefits of stopping, and where to obtain assistance in stopping if available. Advise all pregnant tobacco users of the health risks to the fetus.
 - d. Oral hygiene and periodontal status at time of examination shall be recorded. Upon initial examination, complete items 5A-5C, SF-603, with additional comments placed in "Remarks" if needed. For all subsequent examinations, describe oral hygiene level and periodontal status in item 17 of SF-603/603-A.
 - e. For all patients 16 years of age or older, blood pressure readings shall be taken and recorded on the CG-5605 and the SF-603/603A at initial and subsequent dental examinations.
1. Recording of Dental Treatments on SF-600. Make entries of dental treatment on SF-600 when the patient is on the sick list and when treatment is related to the condition for which the patient is admitted. Such entries shall be made and signed by the dental officer. Notes concerning conditions of unusual interest and of medical or dental significance may be made when appropriate.

Section D - Clinical Records.

1. Purpose and Background. The Clinical Record (CG-3443-1) is the chronological medical and dental record of a nonactive duty beneficiary (dependent or retiree) eligible for health care at a Coast Guard facility. The primary reasons for compiling a clinical record are:
 - a. To develop records to facilitate and document the health condition in order to provide health care and to provide a complete account of such care rendered, including diagnosis, treatment, and end result.
 - b. To protect the Government, the individual concerned, and the individual's dependents: It may be used;
 - (1) to provide, plan and coordinate health care;
 - (2) to aid in preventive health and communicable disease control programs; in reporting medical conditions required by law to Federal, state, and local agencies;
 - (3) to compile statistical data; for research; to teach health services personnel;
 - (4) to determine suitability of persons for service or assignments;
 - (5) to adjudicate claims and determine benefits; for law enforcement or litigation;
 - (6) to evaluate care provided;
 - (7) to evaluate personnel and facilities for professional certification and accreditation, and
 - (8) **To facilitate communication among health care providers, utilization managers, quality assurance and medical records personnel.**
 - c. To aid in identifying deceased persons when other means may be inadequate.
2. Contents of Clinical Records.
 - a. Each clinical record shall consist of CG-3443-1 with dental and medical records arranged in the following bottom to top sequence:
 - (1) Right Side - Dental: CG-3443-2 Dental Record Cover* with CG-5266 (Drug Sensitivity Sticker)*, containing the following:
 - (a) SF-522, Authorization for Administration of Anesthesia and for Performance of Operations and Other Procedures*
 - (b) SF-513 Consultation Sheet
 - (c) NAVMED 6660 Periodontal Screening
 - (d) SF-603, Dental Record - Continuation*
 - (e) SF-603A, Dental Record*
 - (f) CG-5605, Dental Health Questionnaire*
 - (2) Right Side - Medical:

- (a) PHS-731, International Certificate of Vaccination*, attached to the lower right corner of the inside of the Clinical Record Cover
- (b) DD-1141, Record of Occupational Exposure to Ionizing Radiation*
- (c) SF-507, Continuation Sheet**
- (d) SF-602, Syphilis Record*
- (e) SF-601, Immunization Record*
- (f) DD-771, Spectacle Order Form*
- (g) SF-520, Electrocardiographic Report*
- (h) SF-519, Radiographic Reports
- (i) SF-514, Laboratory Reports (or SF-545, Laboratory Report Display*)
- (j) SF-541, Gynecologic Cytology*
- (k) SF-515, Tissue Examination*
- (l) SF-522, Authorization For Administration of Anesthesia and for Performance of Operations and Other Procedures*
- (m) SF-513, Consultation Sheet*
- (n) SF-502, Narrative Summary*
- (o) CG-5447, Occupational Medical Surveillance and Evaluation Program*
- (p) DD-2807-1, Report of Medical History*
- (q) DD-2808, Report of Medical Examination*
- (r) SF-558, Emergency Care and Treatment
- (s) SF-600, Chronological Record of Medical Care
- (t) DD-2766, Adult Preventive and Chronic Care Flowsheet Form
- (u) CG-5266, Drug Sensitivity Sticker*
- (v) **DD-2870, Authorization for Disclosure**
- (w) **DD-2871, Request for Restriction of Information**

* When required

** SF-507's are attached to and filed after the form is continued

- b. File forms of the same number in their assigned sequence, with the most recent placed on top of each previous form, i.e., file SF-600 dated 3 AUG 89 on top of SF-600 dated 20 MAY 86.
 - c. Enter all dates on Clinical Record forms, including the Clinical Record Cover, in the following sequence: day (numeral), month (in capitals abbreviated to the first three letters), and year (numeral); i.e., 30 AUG 86.
3. Extraneous Attachments. In order to ensure that the clinical record is an accurate, properly documented, concise and dependable record of the medical and dental history

of the individual, keep extraneous attachments to a minimum. When they are necessary, file them beneath all other forms.

4. Opening Clinical Records. Open a Clinical Record when an eligible non-active duty beneficiary initially reports to a Coast Guard health care facility for treatment.
5. Terminating Clinical Records. The Clinical Record shall be terminated four years after the last record entry. Make an entry on SF-600 explaining the circumstances under which the record was terminated. Forward the record, **placed in a sealed envelope labeled “Sensitive Medical Information – Confidential,”** to:

Dependent Records:

National Personnel Records Center
GSA (Civilian Personnel Records)
11 Winnebago Street
St. Louis, MO 63118-4126

Military Records:

National Personnel Records
Center (MPR)
9700 Page Avenue
St. Louis, MO 63132-5100

6. Custody of Clinical Records.
 - a. Clinical Records shall be retained in the custody of the Chief, Health Services Division of the unit providing care. At times when there is no medical or dental officer, the clinical record will become the responsibility of the senior health services department representative.
 - b. The name, grade, or rate of the health care provider making entries in clinical records shall be typed, stamped, or printed under their official signatures. Do not use facsimile signature stamps.
 - c. If an erroneous entry is made in a Clinical Record, the author of the entry shall draw a diagonal line through the complete entry, make an additional entry showing wherein and to what extent the original entry is in error, and initial clearly next to the correction.
 - d. Each health care provider is responsible for the completeness of the entries they make on any medical or dental form in the Clinical Record.
 - e. Nothing shall be removed from the Clinical Record except under conditions specified in this Manual.
7. Safekeeping of Clinical Records. Clinical Records are the property of the Federal government and must be handled in accordance with the provisions of the Privacy Act of 1974 and the Freedom of Information Act. Guidance in this area is contained in The Coast Guard Freedom of Information and Privacy Acts Manual, COMDTINST M5260.3 (series).
 - a. Since Clinical Records contain personal information of an extremely critical or sensitive nature, they are considered class III records requiring maximum security (high security locked cabinets or areas).
 - b. Except as contained in the The Coast Guard Freedom of Information and Privacy Acts Manual, COMDTINST M5260.3(series), the information contained in Clinical Records shall not be disclosed by any means of communication to any person or to

any agency, unless requested in writing by or with the prior consent of the individual to whom the record pertains. It is the requestor's responsibility to obtain the consent.

8. Transfer of Clinic Records.

- a. When dependents of active duty personnel accompany their sponsor to a new duty station, the Chief, Health Services Division, his designee, the Executive Officer, or the senior health services department representative shall ensure that the "TRANSFERRED TO" line of the health Record Receipt form, NAVMED 6150/7, is completed in accordance with Chapter 6-B-5 of this Manual.
- b. A DD 877 shall be initiated for each record transferred. **Send records using a service that provides a tracking number, such as Priority Mail Delivery Confirmation, Certified Mail, Insured Mail, or FedEx/Express Mail if time is critical**, to the Coast Guard clinic serving the gaining unit. Express mail and Federal Express should be used only when absolutely necessary and not as a general rule. In instances where the family member will not be located near a Coast Guard Clinic, the record may be mailed to the appropriate MTF. This form can be located on the internet at; <http://web1.whs.osd.mil/ICDHOME/DD-0999.htm>
- c. If the family members will no longer receive care through a military primary care manager, the family member may be given a copy of the clinical record contents to carry with them. The original clinical record will be retained at the clinic serving the unit where the sponsor was last assigned.
- d. Clinics will give family members written information containing address and POC information to facilitate requests for record copies after transfer. All requests for clinical record copies must be in writing. The family member may request that a copy of the record be forwarded to their new care provider once they arrive at the new location, or they may request that the original record be forwarded to their new military primary care manager once they arrive at the new location. In these cases, the clinic shall send a copy of the clinical record contents to the care provider within 10 working days of receipt of the written request. If the clinic cannot comply with this requirement for some reason, the family member will be notified within 10 working days of the request of a projected date when the record copy will be available.
- e. In any instance where there is concern about potential loss of the clinical record, or that its contents may become unavailable to the treating clinic or its provider, the Clinic Administrator or the Chief, Health Services Division shall direct that copies of parts or all of the clinical record shall be made and retained at the clinic.
- f. Originals and copies of clinical records shall be retained and subsequently archived in accordance with directions contained in the Paperwork Management Manual, COMDTINST 5212.12(series).

9. Lost, Damaged, or Destroyed Clinical Records.

- a. If a Clinical Record is lost or destroyed, the unit which held the record shall open a new record. The designation "REPLACEMENT" shall be stamped or marked on the cover. If the missing Clinical Record is recovered, insert in it any additional

information or entries from the replacement record, then destroy the replacement record cover.

- b. Clinical Records which become illegible, thus destroying their value as permanent records, shall be duplicated. The duplicate shall, as nearly as possible, be an exact copy of the original record before such record became illegible. The new record shall be stamped or marked "DUPLICATE" on the cover. The circumstances necessitating the duplication shall be explained on the SF-600. Forward Clinical Records replaced by duplicate records to the National Personnel Records Center.

10. Clinical Record Forms.

- a. CG-3443-1 (Clinical Record Cover). See Encl (1), pg 4-40.

- (1) General. The Clinical Record Cover is used whenever a Clinical Record is opened on dependents or retirees.

- (2) Detailed Instruction's:

- (a) Last Name. Record the last name in all capital letters.

SMITH

- (b) Given Name(s). Record given name(s) in full without abbreviation. If the individual has no middle name or initial, use the lower case letter "n" in parentheses (n). If the individual has only a middle initial(s), record each initial in quotation marks. When "Jr." or "II" or other similar designations are use, they shall appear after the middle name or initial.

SMITH, Helen (n)

Last Name First Name Middle Name

- (c) Date of Birth. Enter day, month (abbreviated JAN, FEB, MAR, etc.) and the year; i.e., 3 FEB 77.
 - (d) Social Security Number. Enter sponsor's SSN.
 - (e) Status. Check the appropriate block; i.e., Retiree USCG, Dependent USPHS, etc.
 - (f) Other. Use this block to indicate special status or other information useful for either proper monitoring of the patient or for aid in identifying the patient or record.
 - (g) Occupational Monitoring. Indicate the reason for occupational monitoring if monitoring is required.
 - (h) Med-Alert. Check this block to indicate that the patient has a medical problem that must be considered in rendering treatment; i.e., allergy, diabetes, cardiac problems, etc. Describe the specific medical problem within the medical record on Problem Summary List, NAVMED 6150/20.

11. **SF-522 (Authorization for Anesthesia, Operations, etc.).** See Encl (1), pg. 4-41.
 - a. Complete SF-522 describing the general nature of the procedure and have the patient sign prior to administering anesthesia (local or general) except for dental anesthesia. Also, complete SF-522 prior to administering immunizing agents and dental surgical procedures such as exodontia, root canal therapy, and periodontal surgery.
 - (1) Insert the form immediately behind Consultation Sheet (SF-513) or as indicated in Section 4-D-2.

Section E - Employee Medical Folders.

1. Purpose and Background. The Employee Medical Folder (EMF), (SF-66 D), is the chronological medical record of Federal employees eligible for health care at Coast Guard facilities. These are the primary reasons for compiling an EMF.
 - a. Develop records to facilitate and document the health condition in order to provide health care and to provide a complete account of care rendered, including diagnosis, treatment, and end result.
 - b. To protect the Government and the individual concerned.
 - c. The information in the EMF is routinely used: to provide, plan and coordinate health care; to aid in preventive health and communicable disease control programs; in reporting medical conditions required by law to Federal, state, and local agencies; to compile statistical data; for research; to teach health services personnel; to determine suitability of persons for service or assignments; to adjudicate claims and determine benefits; for law enforcement or litigation; to evaluate care provided; and to evaluate personnel and facilities for professional certification and accreditation.
2. Custody of Employee Medical Folders (EMF's).
 - a. EMF's are the property of the Federal government handled in accordance with the provisions of the Privacy Act of 1974 and the Freedom of Information Act. Guidance in this area is contained in The Coast Guard Freedom of Information and Privacy Acts Manual, COMDTINST M5260.3 (series).
 - (1) Since EMF's contain personal information of extremely critical or sensitive nature, they are considered class III records according to The Coast Guard Freedom of Information and Privacy Acts Manual, COMDTINST M5260.3 (series), requiring maximum security (high security locked cabinets or areas). Except as contained in The Coast Guard Freedom of Information and Privacy Acts Manual, COMDTINST M5260.3 (series), the information contained in the EMF shall not be disclosed by any means of communication to any person or to any agency, unless requested in writing by or with the prior consent of the individual to whom the record pertains. It is the responsibility of the requester to obtain the consent.
 - b. EMF's shall be retained in the custody of the medical officer of the unit at which the individual is employed. At no time shall individual employees keep or maintain their own records.
 - c. Individuals may examine their EMF in the presence of a health services department representative, providing it does not interrupt the scheduled mission of the unit and there is no information contained therein which would be detrimental to the individual's mental well-being.
 - d. Health services personnel making entries in EMF shall ensure that all entries, including signatures, are neat and legible. Signature information shall include the name and grade or rate. Do not use facsimile signature stamps.

- e. If an erroneous entry is made in an EMF, draw a diagonal line through the complete entry. Make an additional entry showing wherein and to what extent the original entry is in error.
 - f. Health services personnel are responsible for the completeness of the entries made on any form while the EMF is in their custody. No sheet shall be removed from the EMF except under conditions specified in this Manual.
 - g. Health services personnel shall ensure that, if EMF's are located in the same office as the Official Personnel Folder (OPF), the records are maintained physically apart from each other.
3. Contents of the Employee Medical Folders.
- a. Each medical folder shall consist of SF-66 D (Employee Medical Folder) with medical records arranged in the following bottom to top sequence:
 - (1) Left Side Dental: Leave blank.
 - (2) Right Side - Medical:
 - (a) PHS-731, International Certificate of Vaccination*, attached to the lower right corner of the inside of the EMF
 - (b) DD-1141, Record of Occupational Exposure to Ionizing Radiation*
 - (c) SF-507, Continuation Sheet**
 - (d) CG-5447, Occupational Medical Surveillance and Evaluation Program*
 - (e) SF-602, Syphilis Record*
 - (f) SF-601, Immunization Record*
 - (g) DD-771, Spectacle Order Form*
 - (h) SF-520, Electrocardiographic Report*
 - (i) SF-519, Radiographic Reports
 - (j) SF-514, Laboratory Reports (or SF-545, Laboratory Report Display*)
 - (k) SF-541, Gynecologic Cytology*
 - (l) SF-515, Tissue Examination*
 - (m) SF-522, Authorization For Administration of Anesthesia and for Performance of Operations and Other Procedures*
 - (n) SF-513, Consultation Sheet*
 - (o) SF-502, Narrative Summary*
 - (p) DD-2807-1, Report of Medical History* DD-2808, Report of Medical Examination*

- (q) SF-558, Emergency Care and Treatment*
- (r) SF-600, Chronological Record of Medical Care
- (s) CG-5357, Outpatient Record
- (t) DD-2766, Adult Preventive and Chronic Care Flowsheet
- (u) CG-5266, Drug Sensitivity Sticker*
- (v) **DD-2870, Authorization for Disclosure**
- (w) **DD-2871, Request for Restriction of Information**

* When required

** SF-507's are attached to and filed after the form is continued.

- b. File forms of the same number in their assigned sequence, with the most recent placed on top of each previous form, i.e., file SF-600 dated 3 AUG 87 on top of SF-600 dated 20 MAY 86.
- c. Enter all dates in the following sequence: day (numeral), month (in capitals abbreviated to the first three letters), and year (numeral); i.e., 30 AUG 86.
- 4. Accountability of Disclosures. The accountability of disclosure of records, as required by **the HIPAA Privacy Regulation** and the Privacy Act of 1974, will be maintained in accordance with Chapter 8, of COMDTINST M5260.2 (series), **in the Protected Health Information Management Tool (PHIMT); see Chapter 14 of this Manual**. The information will be retained for **six** years after the last disclosure or for the life of the record, whichever is longer.
- 5. Opening Employee Medical Folder. Open an EMF when an eligible Federal employee initially reports for treatment.
- 6. Terminating Employee Medical Folders. Terminate the EMF in accordance with the Coast Guard Paperwork Management Manual, COMDTINST 5212.12 (series). Make an entry on SF-600 explaining the circumstances under which the folder was terminated.
- 7. Transferring to Other Government Agencies. When transferring an EMF to other agencies, complete a Request for Medical/Dental Records or Other Information (DD-877).
- 8. Lost, Damaged, or Destroyed Employee Medical Folders.
 - a. If an EMF is lost or destroyed, the unit which held the record shall open a complete new Employee Medical Folder. Stamp or mark "REPLACEMENT" on the cover. If the missing folder is recovered, insert in it any additional information or entries from the replacement folder, then destroy the replacement folder.
 - b. EMF's which become illegible, thus destroying their value as permanent records, will be duplicated. The duplicate shall, as nearly as possible, be an exact copy of the original record before such record becomes illegible. Stamp or mark "DUPLICATE" on the new record cover. Document the circumstances necessitating the duplication on an SF-600. Forward EMF's replaced by duplicate records to the National Personnel Records Center.

9. **SF-66 D (Employee Medical Folder)**. See Encl (1), pg. 4-42. Detailed instructions are:

a. Last Name. Record the last name in all capital letters.

BROOKS

b. Given Name(s). Record given name(s) in full without abbreviation. If the individual has no middle name or initial, use the lower case letter "n" in parentheses (n). If the individual has only a middle initial(s), record each initial in quotation marks. When "Jr." or "II" or other similar designations are use, they shall appear after the middle name or initial.

BROOKS Cecilia (n)

Last Name First Name Middle Name

c. Date of Birth. Enter day, month (abbreviated JAN, FEB, MAR, etc.) and the year; i.e., 8 JUN 62.

d. Social Security Number. Enter SSN.

Section F -Inpatient Medical Records.

1. Purpose and Background.

- a. Certain Coast Guard health care facilities have the capability and staffing to provide overnight care. Overnight care is defined as any period lasting more than four hours during which a beneficiary remains in the facility under the care or observation of a provider. By definition, overnight care may last less than 24 hours or it may last several days. Overnight care is utilized when a patient's condition or status requires observation, nursing care, frequent assessment, or other monitoring.
- b. Inpatient Medical Records (IMRs). Facilities providing overnight care shall create an Inpatient Medical Record (IMR) separate from the Health Record for the purpose of recording and preserving information related to the overnight care. The IMR shall be assembled as soon as a person is identified as needing overnight care. The IMR shall contain the following forms in a TOP TO BOTTOM sequence:
 - (1) **Inpatient Medical Record Cover Sheet and Privacy Act Statement**. See Encl (1), pg 4-43.
 - (2) SF-508, Doctor's Orders (most recent on top)
 - (3) SF-506, Clinical Record/Physical Exam
 - (4) SF-502, Narrative Summary
 - (5) SF-509, Doctor's Progress Notes (most recent on top)
 - (6) SF-511, Vital Signs Record
 - (7) SF-514, Laboratory Report Display
 - (8) SF-519, Radiologic Reports
 - (9) Patient Care Kardex
 - (10) Medication Kardex
 - (11) SF-513, Consultation sheet
 - (12) Miscellaneous forms (e.g., audiograms)
- c. Abbreviated Inpatient Medical Records (AIMRs). For patients who receive overnight care lasting 24 hours or less, an Abbreviated Inpatient Medical Record (AIMR) shall be created. The AIMR shall consist of at least an Inpatient Medical Record Cover Sheet, Privacy Act Statement, and an DD-2770, Abbreviated Medical Record form. SF-545, Laboratory Reports; SF-519, Radiologic Consultation Reports; Kardexes; and other forms may be included at the discretion of the clinic. The AIMR shall be maintained while in use, completed, stored, and retired following the same requirements as listed for IMRs below.
- d. During the time that the patient is receiving care, the IMR may be maintained in a loose-leaf binder, clipboard, or other convenient device, at the facility's discretion. Devices should be chosen and maintained so that the privacy, **confidentiality and security** of the patient information contained therein is protected at all times.

Keeping or storing the record at the patient's bedside is discouraged for privacy reasons.

- e. Once the patient is released from overnight care, providers shall have 48 hours to complete their notations in the record (excluding dictated entries). All laboratory, radiologic and consultation forms shall also be included in the IMR within 48 hours of the patient's release from overnight care.
 - f. Dictated entries shall be entered in the medical record within 7 days of discharge. The record may be held in medical records and flagged as needing a dictated entry.
 - g. After all notations, lab reports, radiology reports and consultations have been entered into the IMR, the IMR forms shall be placed in a bifold paper jacket (form CG-3443-1), and secured via a two prong device. The medical records staff is responsible for ensuring that the documents are in the correct order and are stored properly.
2. Maintenance and Storage. IMRs are the property of the Federal Government and must be handled in accordance with the provisions of the **HIPAA Regulations**, the Privacy Act of 1974 and the Freedom of Information Act. Guidance concerning these acts is contained in The Coast Guard Freedom of Information and Privacy Acts Manual, COMDTINST M5260.3 (series). All requirements and directions for handling and storing IMRs also apply to AIMRs.
- a. Since IMRs contain personal information of an extremely critical or sensitive nature, they are considered to be Class III records requiring maximum security (high security locked cabinets or areas). IMRs shall be stored in well ventilated and sprinklered areas. Fire-resistant cabinets or containers shall be used for storage whenever possible.
 - b. IMRs shall be retained at the health care facility which created the record. IMRs will not be transferred with personnel who change duty stations. Copies of the IMR may be given to the individual if such a request is made in writing, or may be released to other persons, e.g., physicians or hospitals, if the patient requests or authorizes such release in writing. All release requests and authorizations will be inserted into the IMR cover.
 - c. IMRs will be retained at the creating health care facility for two (2) years after the date the patient is released from overnight care.
3. Disposition of IMRs. The IMR will be forwarded to the National Personnel Records Center (NPRC) as described in Coast Guard Paperwork Management Manual, COMDTINST M5212.12(series), two years after the date the patient was released from inpatient care. The NPRC requirements must be met in order for the NPRC to accept the records.
- a. Records must be sent in prescribed standard cubic foot cartons. **See Encl (1), pg.4-45.** Cartons are available from the General Services Administration Federal Supply Service (FSS). The FSS stock number is NSN 8115-00-117-8344. All non-standard cartons will be returned at the expense of the originating organization.

- b. NPRC does not accept accessions of less than one cubic foot. Small amounts shall be held until a volume of one cubic foot or more is reached.
 - c. Print the accession number on each box, starting in the upper left hand corner **See Encl (1), pg. 4-45** . Mark the front of the box only. The accession number consists of the RG, which is always 26 for the Coast Guard, the current FY in which the records are being shipped, and a four digit number assigned by NPRC (see 4-F-3.j. for SF-135 preparation). Mark the front of the box only. Ensure that the information printed on the box is not obscured in any way, and that removal of tape or other sealing materials will not remove vital information.
 - d. Number each box consecutively, e.g., 1 of 8, 2 of 8, 3 of 8, 8 of 8; or 1/8, 2/8, 3/8...8/8, in the upper right hand corner. See Encl (1), pg. 4-45 for placement.
 - e. Records shall be arranged in each storage box either alphabetically or numerically. Print the identifier of the first and last record/folder that is contained in the box on the center front of each box as shown in Encl (1), pg. 4-45.
 - f. Enclose in the first box of each accession one copy of the SF-135 and any alphabetical or numerical listing needed to reference the records.
 - g. Ship records together so they arrive at the NPRC at the same time. Shipments of 10 cubic feet or more shall be palletized as shown in **Encl (1), pg. 4-46.**
 - h. Records must be shipped within 90 days of being assigned an accession number. Failure to ship within 90 days will void the accession number.
 - i. Each clinic that transfers IMRs to NPRC must keep a master list (hard copy) of the records sent. The master list must be retained at the clinic for a period of 50 years.
 - j. All shipments to NPRC must be accompanied by SF-135, Records Transmittal and Receipt form. The transmittal form must include the name on the record and the individual's social security number. The accession number elements include the RG which is always 26 for the Coast Guard, the current FY during which the record is shipped, and the 4 digit sequential number assigned by NPRC. Also include the date sent. Complete SF-135 preparation and submission instructions are contained in the Coast Guard Paperwork Management Manual, COMDTINST M5212.12(series).
4. Inpatient Medical Record Forms and Required Entries.
- a. **SF-508, Doctor's Orders.** See Encl (1), pg 4-47.
 - (1) Purpose. SF-508 is used to record written and verbal orders of the medical or dental staff; record that nurses have noted orders; record automatic stop dates for medications and time limited treatments; and record the RN review of orders which shall be performed every 24 hours.

(2) Preparation

- (a) When Prepared. SF-508 shall be used to communicate doctor's orders for all persons admitted to the medical facility inpatient area.
- (b) Required Entries.
 - 1 Patient identification information may be written in or overprinted using a patient identification card.
 - 2 The date and time at which the order is written by the provider will be listed under the start column. If a verbal order is received, the date and time at which the order was received will be noted by the person who received the order in the start column. All verbal orders must be countersigned by the admitting provider on the next working day.
 - 3 Certain orders may be defined as time limited, e.g., complete bedrest for 24 hours, tilts q 8 hours X 3, etc. In addition, the facility shall define the length of time between renewal of orders for medications, treatments, etc. For orders which are time limited, the date and time when the order expires shall be noted under the stop column.
 - 4 All doctor's orders shall be listed on the form under drug orders. Orders shall be printed clearly in black ink. Only approved abbreviations shall be used. Nursing staff and/or health services technicians are required to contact the provider who wrote the order if there are any questions or difficulty encountered in reading the written order.

b. **SF-506, Clinical Record/Physical Exam**. See Encl (1), pg. 4-48.

- (1) Purpose. SF-506 is part of the inpatient medical record. It is used to record information obtained from physical examinations.
- (2) Preparation. When Prepared. SF-506 shall be prepared when a patient is admitted to the medical facility.
 - (a) Required Entries.
 - 1 Patient identification information may be written in or printed using a patient identification card.
 - 2 Fill in the date that the exam is conducted in the upper left corner. The patient's self reported height may be used. Patients shall be weighed accurately on the day of admission and the weight entered as present weight. Vital signs to include temperature, pulse and blood pressure are recorded in the appropriate boxes. Rectal temperatures shall be identified by an "R" after the temperature reading. Axillary temperatures in adults are unreliable and will not be used.

- 3 A physical examination must be thorough, recorded accurately, and contain sufficient information to substantiate the treatment plan and interventions. Examination notations may be continued on the reverse of the form. If the back of the form is used, this must be indicated on the front of the form. The examiner will sign the form at the end of his/her notations and use a printed ink stamp to clearly mark name, rank, and SSN.
- c. SF-509, Progress Notes. See Encl (1), pg 4-50
- (1) Purpose. SF-509 is part of the inpatient medical record. It is used to record the progress of the patient's condition, therapy or other treatment(s), as well as any other information relevant to the patient's condition or treatment such as laboratory tests and results.
 - (2) Preparation.
 - (a) When Prepared. SF-509 shall be prepared when a patient is admitted to the medical facility inpatient area.
 - (b) Required Entries.
 - 1 Patient identification information may be written in or overprinted using a patient identification card.
 - 2 Fill in the left column with the date and time at which the entry is being created. Begin writing to the right of the solid brown line. Notes will be written in SOAP format (see 4-B-5.a.(4)). The person creating the note will sign the form at the end of his/her notations and use a printed ink stamp to clearly mark name, rank, and SSN.
- d. SF-511, Vital Signs Record. See Encl (1), pg.51.
- (1) Purpose. SF-511 shall be used to document vital sign measurements, height, weight, hospital day and, if appropriate, postoperative day for patients admitted to the medical facility inpatient area.
 - (2) Preparation.
 - (a) When Prepared. SF-511 shall be prepared when a patient is admitted to the medical facility inpatient area.
 - (b) Required Entries.
 - 1 Patient identification information may be written in or overprinted using a patient identification card.
 - 2 Hospital day one shall be the day of admission.
 - 3 If the patient undergoes an invasive procedure, "op" shall be written after the word post in the left column. The day of surgery shall be noted by writing "DOS" in the appropriate column. The day

following the day of surgery is post-op day one. Post-op days shall be numbered consecutively thereafter.

- 4 The month in which the patient is admitted shall be written on the fifth line, first column. The year shall be completed by writing in the correct numerals after "19" on the fifth line.
- 5 The calendar date on which the patient is admitted shall be written in on the line next to the word day, e.g., if the patient is admitted on 3 June, the hospital day is one, and a "3" is written on the line next to the word day.
- 6 The hour at which the vital sign measurements are to be made are noted in the spaces next to the word hour. Use 24 hour clock notations, e.g., 11 p.m. is 2300, etc.
- 7 Once vital signs have been measured, they shall be recorded on the form using the symbols for pulse and temperature. Symbols are placed in the columns, not on the brown dotted lines.
- 8 Blood pressure measurements are written in the spaces to the right of the words "blood pressure". The first measurement made after midnight is written in the top left column, the second is written below it. The first measurement made after noon is written in the top box in the right side column, the second below that, etc. Blood pressure may also be represented by x marks placed at the systolic and diastolic measurements corresponding to the scale for pulse measurements.
- 9 Other vital signs measurements or intake and output measurements may be written in the spaces on the lower part of the form, or a local overprint/stamp may be used.
- 10 Both sides of the form will be used. If the second side of the form is used, the word "continued" will be clearly written on the bottom of the first page.

e. SF-514, Laboratory Reports.

- (1) Purpose. SF-514 is part of the inpatient medical record. It is used to keep laboratory report forms neat, in proper order, make them easily accessible to caregivers, and stores them as part of the inpatient medical record. SF-545, Clinical Record - Laboratory Report Display may be used in lieu of SF-514.
- (2) Preparation.
 - (a) When Prepared. SF-514/SF-545 shall be prepared when a patient is admitted to the inpatient medical area.
 - (b) Required Entries.
 - 1 Patient identification information may be written in or overprinted using a patient identification card.

- 2 Reports (or chits) may be attached to the form using either the self adhesive on the back of the chit, or by neatly placing a strip of clear adhesive tape horizontally across the top of the report, so that the lower half of the tape strip is touching the chit and the upper half is sticking to the SF-514/SF-545.
- f. [SF-519, Radiologic Consultation Reports.](#)
- (1) Purpose. SF-519 is part of the inpatient medical record. It is used to collect radiological reports for easy access by caregivers and to store the reports with the inpatient medical record.
 - (2) Preparation.
 - (a) When Prepared. SF-519 shall be prepared when a patient is admitted to the inpatient medical area.
 - (b) Required Entries. Reports shall be attached to the form using the self stick adhesive on the back of the report or clear adhesive tape.
- g. [DD-2770 \(replaces SF 539\) Abbreviated Medical Record.](#) See Encl (1), pg. 4-52.
- (1) Purpose. DD-2770 is used to record history, exam findings, patient progress, doctor's orders, vital signs, output, medications and nurse's notes for patients requiring overnight care who remain 24 hours or less.
 - (2) Preparation.
 - (a) When Prepared. DD-2770 may be used for any overnight care patient for whom total stay is anticipated to be 24 hours or less. If length of stay exceeds 24 hours, a full IMR must be initiated to provide proper documentation of the patient's stay. The DD-2770 shall be prepared when a short stay patient is admitted to the inpatient medical area.
 - (b) Required Entries.
 - 1 Patient identification information may be written in or overprinted using a patient identification card.
 - 2 History, chief complaint, and condition on admission must be documented in the top box on page one. Date of admission shall be noted here also.
 - 3 Physical examination findings shall be noted in the center box on page one. Physical exam findings shall be completely noted and appropriate to the condition. Deferred exams, such as rectal exams, shall be noted as such.
 - 4 The patient's progress over the 24 hour period between admission and discharge will be noted by the medical officer in the third box on page one. Date of discharge and final diagnosis shall be noted here also.

- 5 The physician shall sign the form in the box provided and use a printed ink stamp to clearly mark his/her name, rank, and SSN. The date the form is signed shall be written in the box provided next to the signature.
 - 6 The location of the clinic or dispensary, for example, Dispensary TRACEN Cape May, shall be written or stamped in the box marked organization.
 - 7 Doctor's orders shall be written only in the space provided on page two. Each order group written shall be dated and signed. A printed ink stamp shall be used by medical officers to mark name, rank, and SSN. All medical and dental orders given during the patient's stay must be recorded. A second page should be started if the number of orders exceeds space available on one page.
 - 8 Vital sign measurements shall be recorded in the spaces provided with the date and time of each notation. Bowel movements and urine output are noted in the columns marked stools and weight.
 - 9 Medications administered and brief notes regarding the patient's condition shall be made in the nurse's notes area. Medication name, dose, route, and time given shall be recorded for each dose of medication administered. Each notation shall be signed with the name, military rank, or title for civilians, e.g., RN or LPN, of the person making the note.
- h. **DD-2870 Authorization for Disclosure of Medical or Dental Information.**
- (1) In order to use or disclose patient health information for purposes beyond the treatment, payment and health care operations and other purposes described in the MHS Notice of Privacy Practices, written authorization from the patient must be obtained on form DD-2870.
- i. **DD-2871 Request to Restrict Medical or Dental Information.**
- (1) Individuals have the right to request restrictions on the use or disclosure of their health information. Requests must be made in writing on form DD-2871. Requests for restriction may be denied upon review by the clinic HIPAA Privacy/Security Official, or the Coast Guard HIPAA Privacy/Security Official.

Section G – Mental Health Records.

1. Active duty: Complete mental health assessments and visits will be done in an IMB, DMB or traditional psychiatric evaluation format and recorded on SF-600, SF-513, IMB, DMB, or typed psychiatric evaluation forms as appropriate. Active duty episodic visits and routine appointments will be recorded on SF-600 in SOAP format. The Objective (“O”) section would include mental status observations and any other pertinent physical findings. Records of active duty mental health assessments and visits will be kept in the main health record (CG-3443). An additional separate mental health record may be created and maintained in a system of records approved by the local QA Committee and kept secure in the mental health practitioner’s office. New patients would be evaluated IAW traditional psychiatric evaluation.
2. Non- Active duty: Separate records of mental health care may be created and maintained in a system of records approved by the local QA Committee and kept secure in the mental health practitioner’s office. Alternatively, the mental health practitioner may elect to keep records of visits in the dependent or retiree’s main based record (CG-3443-1). Should the practitioner elect to maintain a separate office based record for non-active duty patients, the main health record (orange jacket) must include, at a minimum, the diagnosis in the problem summary listing, current psychiatric medications on the SF-600, and lab work ordered by the mental health provider. New patients would be evaluated IAW traditional psychiatric evaluation. Episodic and follow up visits would be recorded in a SOAP format.
3. Psychiatric evaluation format: The psychiatric evaluation shall include, at a minimum: patient information, chief complaint, history of present illness, past history (psychiatric symptoms, diagnoses, and care medical illness, surgeries, current medications, allergies, alcohol & drug history), personal history, family history, mental status exam, assessment (DSM-IV), prognosis, and plan. Included in all assessments and other visits as appropriate will be an estimation of potential for harm to self or others. In addition, notes should contain sufficient information to establish that the criteria for any new DSM based diagnosis are met.
4. Custody of Mental Health Records: Records kept in the mental health practitioner’s office are property of the CG and copies should be available to other civilian practitioners or agencies at the patient’s request. These records should also be available to other CG providers, as part of an official records review process, and as directed in Section 4.A.5. of this Manual.

ADULT PREVENTIVE AND CHRONIC CARE FLOWSHEET <i>(This form is subject to the Privacy Act of 1974 – Use DD form 2005)</i>								
1. ALLERGIES								
a. MEDICATION ALLERGIES				b. OTHER ALLERGIES				
2. CHRONIC ILLNESS				3. MEDICATIONS				
4. HOSPITALIZATIONS/SURGERIES								
5. COUNSELING								
F	FITNESS	a. DATE						
D	DENTAL	b. AGE						
I	INJURY PREVENTION	c. TOPIC						
N	NUTRITION/FOLATE							
C	CANCER PREVENTION							
S	SAFE SEX							
FP	FAMILY PLANNING	d. DATE						
Rx	PRESENT MEDICATIONS	e. AGE						
MH	MENTAL HEALTH/STRESS/SUICIDE/ OCCUPATIONAL STRESS	f. TOPIC						
H	HORMONE/CALCIUM REPLACEMENT	g. DATE						
To	TOBACCO	h. AGE						
A	ALCOHOL/SUBSTANCE ABUSE	i. TOPIC						
t	TRAVEL							
O.	OCCUPATIONAL EXPOSURE (HEARING THRESHOLD CHANGES/CUMULATIVE TRAUMA DISORDER)							
		j. DATE						
		k. AGE						
		i. TOPIC						
ADVANCE DIRECTIVES: DATE FILED								
PATIENT'S IDENTIFICATION (Use this space for mechanical imprint) <div style="text-align: center; color: blue;"> SUPPLIED (Navy) 2766-0102-LF-984-8400, pkg-100 </div>				RECORDS MAINTAINED AT:				
				PATIENT'S NAME			SEX	
				LAST	FIRST	M.I.		
				RELATIONSHIP TO SPONSOR		STATUS	RANK/GRADE	
				SPONSOR'S NAME (Last ,First, Middle Initial)			DEPT/SERVICE	
ORGANIZATION		SSN/ID NUMBER		DATE OF BIRTH				

ADULT PREVENTION AND CHRONIC CARE FLOWSHEET									
6. FAMILY HISTORY (M = Mother, F = Father, S = Sibling, MGM = Maternal Grandmother, MGF = Maternal grandfather, PGM = Paternal Grandmother, PGF = Paternal Grandfather)									
a. CANCER (Specify)									
b. CARDIOVASCULAR DISEASE (Specify)									
c. DIABETES (Specify)									
d. MENTAL ILLNESS/CHEMICAL DEPENDENCY (Specify)									
7. SCREENING EXAMS (* = Actual Result, ** = Tricare Benefit, N = Normal, X = Abnormal, E = Done Elsewhere, R = Refused, NA = Not Indicated) (• = Next Due)									
a. TEST	b. FREQUENCY	c. YEAR							
		d. AGE							
(1) CLINICAL DISEASE PREV EVAL/PHA (HEAR)	ANNUAL								
* (2) WEIGHT	ANNUAL FOR ACTIVE DUTY								
* (3) HEIGHT	ANNUAL FOR ACTIVE DUTY								
* (4) BLOOD PRESSURE	ONCE q 2 YRS for BP < 130/85, ANNUAL IF GREATER								
* (5) CHOLESTEROL**	*q 5 YRS FOR AGE ≥ 18 q YR if PREV ABN								
(6) HEARING	CLINICAL DISCRETION								
(7) SKIN EXAM (Cancer)	ANNUAL IF AT RISK								
(8) ORAL/DENTAL **	ANNUAL								
(9) EYE/VISION **	ROUTINE ACUITY WITH PERIODIC ASSESSMENT DIABETES ANNUAL GLAUCOMA CHECK: Blacks q 3-5 yrs age 20-39 All q 2-4 years age 40-64								
(10) BREAST EXAM	ANNUAL: ≥ 40 YRS								
(11) MAMMOGRAM **	BASELINE@ 40, q 2 YRS 40-50, ANNUALLY > 50								
(12) PAP ** (Digital Rectal Exam)	BASELINE: AGE 18 OR ONSET OF SEXUAL ACTIVITY AFTER 3 NL ANNUAL EXAMS, PERFORM q 1-3 years								
(13) FECAL OCCULT BLOOD	ANNUAL ≥ 50 yrs								
(14) SIGMOID	EVERY 3-5 YRS: ≥ 50 YRS								
(15) COLONOSCOPY	HIGH RISK q 5 YRS ≥ YRS								
(16) TESTICULAR	HIGH RISK ANNUAL 13-39 YRS								
(17) PROSTATE ** ** (DIGITAL RECTAL EXAM)	WITH P.E. ≥ 40 YRS (Presently Recommended annually)								
(18) RUBELLA SCREEN (Females)	ONCE BETWEEN AGES 12-18 YRS (Unless prev vaccinated)								
(19) OCCUPATIONAL SCREENING EXAMS	APPROPRIATE TO EXPOSURES								
(20)									
(21)									
(22)									

ADULT PREVENTION AND CHRONIC CARE FLOWSHEET											
8. OCCUPATIONAL HISTORY/RISK											
a. PRP		YES		NO							
b. FLYING STATUS		YES		NO							
9. IMMUNIZATIONS <i>(Enter numeric class in sub block)</i>											
(1) IMMUNIZATION		(2) DATE <i>(ddmmmyyyy)</i>		(1) IMMUNIZATION		(2) DATE <i>(DDMMYYYY)</i>		(1) IMMUNIZATION		(2) DATE <i>(ddmmmyyyy)</i>	
a. HEP A # 1				f. MMR # 1				j. TD <i>(q 10 YRS)</i> <i>(Last)</i>			
b. HEP A # 2				g. MMR #2				k. TD <i>(DUE)</i>			
c. HEP B # 1				h. PNEUMOCOCCUS				l. YELLOW FEVER <i>(LAST)</i>			
d. HEP B #2				i. POLIO OPV = O IPV = I				m. YELLOW FEVER			
n. TYPHOID <i>(Enter numeric class in sub block)</i> ORAL = 0 TYPHUM Vi = 1. TYPHOID USP = 2				(1) DATE		(2) DATE		(3) DATE		(4) DATE	
O. ANTHRAX		(1) INITIAL DATE		(2) 2 WEEK DATE		(3) 4 WEEK DATE		(4) 6 MONTH DATE		(5) 12 MONTH DATE	
p. PPD <i>(Enter mm and date)</i>		(1) (a) mm		(2) (a) mm		(3) (a) mm		(4) (a) mm		(5) (a) mm	
		(b) DATE		(b) DATE		(b) DATE		(b) DATE		(b) DATE	
q. INFLUENZA		(1) DATE		(2) DATE		(3) DATE		(4) DATE		(5) DATE	
r. VARICELLA		(1) DATE		(2) DATE		u. JAPANESE B ENCEPHALITIS		(1) DATE		(3) DATE	
s. MENINGO		(1) DATE		(2) DATE		v. OTHER <i>(Specify)</i>		(1) DATE		(2) DATE	
t. ADENO		(1) DATE		(2) DATE				(1) DATE		(2) DATE	
10. READINESS <i>(Glucose-6-phosphate dehydrogenase)</i>											
a. DNA		DATE:		b. BLOOD TYPE		DATE:		c. G-PD		DATE:	
e. PERMANENT PROFILE CHANGE				(1) DATE		(2) P:		(3) U:		(4) L:	
f. GLASSES/GAS/MASK Rx:		(1) DATE		(2) DATE		(3) DATE		(4) DATE		(5) DATE	
g. DENTAL EXAM <i>(Enter numeric class in sub block)</i>		(1) DATE		(2) DATE		(3) DATE		(4) DATE		(5) DATE	
h. HIV TESTING		(1) DATE		(2) DATE		(3) DATE		(4) DATE		(5) DATE	
i. FITNESS <i>(In sub block enter P = Pass, F = Fail, W = Waiver)</i>		(1) DATE		(2) DATE		(3) DATE		(4) DATE		(5) DATE	
		(1) DATE		(2) DATE		(3) DATE		(4) DATE		(5) DATE	
		(1) DATE		(2) DATE		(3) DATE		(4) DATE		(5) DATE	
11. PRE/POST DEPLOYMENT HISTORY											
a. LOCATION											
(1) PREDEPLOYMENT		(a) DATE		(b) DATE		(c) DATE		(d) DATE		(e) DATE	
(2) POSTDEPLOYMENT		(a) DATE		(b) DATE		(c) DATE		(d) DATE		(e) DATE	
b. LOCATION											
(1) PREDEPLOYMENT		(a) DATE		(b) DATE		(c) DATE		(d) DATE		(e) DATE	
(2) POSTDEPLOYMENT		(a) DATE		(b) DATE		(c) DATE		(d) DATE		(e) DATE	
c. CHART AUDIT											

[illegible]

AUTHORIZED FOR LOCAL REPRODUCTION

SAMPLE FORM

4-6



REPORT OF MEDICAL EXAMINATION		1. DATE OF EXAMINATION (YYYYMMDD)		2. SOCIAL SECURITY NUMBER	
PRIVACY ACT STATEMENT AUTHORITY: 10 USC 504, 505, 507, 532, 978, 1201, 1202, and 4346; and E.O. 9397. PRINCIPAL PURPOSE(S): To obtain medical data for determination of medical fitness for enlistment, induction, appointment and retention for applicants and members of the Armed Forces. The information will also be used for medical boards and separation of Service members from the Armed Forces. ROUTINE USE(S): None. DISCLOSURE: Voluntary; however, failure by an applicant to provide the information may result in delay or possible rejection of the individual's application to enter the Armed Forces. For an Armed Forces member, failure to provide the information may result in the individual being placed in a non-deployable status.					
3. LAST NAME - FIRST NAME - MIDDLE NAME (SUFFIX)		4. HOME ADDRESS (Street, Apartment Number, City, State and ZIP Code)		5. HOME TELEPHONE NUMBER (Include Area Code)	
6. GRADE	7. DATE OF BIRTH (YYYYMMDD)	8. AGE	9. SEX <input type="checkbox"/> Female <input type="checkbox"/> Male	10. RACE <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Black <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> White	
11. TOTAL YEARS GOVERNMENT SERVICE a. MILITARY b. CIVILIAN		12. AGENCY (Non-Service Members Only)		13. ORGANIZATION UNIT AND UIC/CODE	
14.a. RATING OR SPECIALTY (Aviators Only)		b. TOTAL FLYING TIME		c. LAST SIX MONTHS	
15.a. SERVICE <input type="checkbox"/> Army <input type="checkbox"/> Coast Guard <input type="checkbox"/> Navy <input type="checkbox"/> Marine Corps <input type="checkbox"/> Air Force		b. COMPONENT <input type="checkbox"/> Active Duty <input type="checkbox"/> Reserve <input type="checkbox"/> National Guard		c. PURPOSE OF EXAMINATION <input type="checkbox"/> Enlistment <input type="checkbox"/> Medical Board <input type="checkbox"/> Other <input type="checkbox"/> Commission <input type="checkbox"/> Retirement <input type="checkbox"/> Retention <input type="checkbox"/> U.S. Service Academy <input type="checkbox"/> Separation <input type="checkbox"/> ROTC Scholarship Program	
16. NAME OF EXAMINING LOCATION, AND ADDRESS (Include ZIP Code)					
CLINICAL EVALUATION (Check each item in appropriate column. Enter "NE" if not evaluated.)					
		Nor- mal	Ab- norm	NE	
17. Head, face, neck, and scalp					
18. Nose					
19. Sinuses					
20. Mouth and throat					
21. Ears - General (Int. and ext. canals/Auditory acuity under item 71)					
22. Drums (Perforation)					
23. Eyes - General (Visual acuity and refraction under items 61 - 63)					
24. Ophthalmoscopic					
25. Pupils (Equality and reaction)					
26. Ocular motility (Associated parallel movements, nystagmus)					
27. Heart (Thrust, size, rhythm, sounds)					
28. Lungs and chest (Include breasts)					
29. Vascular system (Varicosities, etc.)					
30. Anus and rectum (Hemorrhoids, Fistulae) (Prostate if indicated)					
31. Abdomen and viscera (Include hernia)					
32. External genitalia (Genitourinary)					
33. Upper extremities					
34. Lower extremities (Except feet)					
35. Feet (See Item 35 Continued)					
36. Spine, other musculoskeletal					
37. Identifying body marks, scars, tattoos					
38. Skin, lymphatics					
39. Neurologic					
40. Psychiatric (Specify any personality deviation)					
41. Pelvic (Females only)					
42. Endocrine					
43. DENTAL DEFECTS AND DISEASE (Please explain. Use dental form if completed by dentist. If dental examination not done by dental officer, explain in Item 44.) <input type="checkbox"/> Acceptable <input type="checkbox"/> Not Acceptable Class _____		44. NOTES: (Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 73 and use additional sheets if necessary.)			
		35. FEET (Continued) (Circle category)			
		Normal Arch		Mild	Asymptomatic
		Pes Cavus		Moderate	
		Pes Planus		Severe	Symptomatic

LAST NAME - FIRST NAME - MIDDLE NAME (SUFFIX)												SOCIAL SECURITY NUMBER																					
LABORATORY FINDINGS																																	
45. URINALYSIS				a. Albumin				46. URINE HCG				47. H/H				48. BLOOD TYPE																	
				b. Sugar																													
TESTS				RESULTS								HIV SPECIMEN ID LABEL				DRUG TEST SPECIMEN ID LABEL																	
49. HIV																																	
50. DRUGS																																	
51. ALCOHOL																																	
52. OTHER																																	
a. PAP SMEAR																																	
b.																																	
c.																																	
MEASUREMENTS AND OTHER FINDINGS																																	
53. HEIGHT			54. WEIGHT lbs.			55. MIN WGT - MAX WGT MAX BF %						56. TEMPERATURE			57. PULSE																		
58. BLOOD PRESSURE									59. RED/GREEN <i>(Army Only)</i>						60. OTHER VISION TEST																		
a. 1ST			b. 2ND			c. 3RD																											
SYS.			SYS.			SYS.																											
DIAS.			DIAS.			DIAS.																											
61. DISTANT VISION						62. REFRACTION BY AUTOREFRACTION OR MANIFEST						63. NEAR VISION																					
Right 20/			Corr. to 20/			By			S.			CX			Right 20/			Corr. to 20/			by												
Left 20/			Corr. to 20/			By			S.			CX			Left 20/			Corr. to 20/			by												
64. HETEROPHORIA <i>(Specify distance)</i>																																	
ES [°]		EX [°]		R.H.		L.H.		Prism div.		Prism Conv CT		NPR		PD																			
65. ACCOMMODATION						66. COLOR VISION <i>(Test used and result)</i>						67. DEPTH PERCEPTION <i>(Test used and score)</i> AFVT																					
Right			Left			PIP			/14			Uncorrected			Corrected																		
68. FIELD OF VISION						69. NIGHT VISION <i>(Test used and score)</i>						70. INTRAOCULAR TENSION																					
												O.D.			O.S.																		
71a. AUDIOMETER			Unit Serial Number						71b. Unit Serial Number						72a. READING ALOUD TEST																		
Date Calibrated (YYYYMMDD)									Date Calibrated (YYYYMMDD)																								
HZ		500		1000		2000		3000		4000		6000		HZ		500		1000		2000		3000		4000		6000				SAT		UNSAT	
Right														Right														72b. VALSALVA					
Left														Left														SAT		UNSAT			
73. NOTES <i>(Continued)</i> AND SIGNIFICANT OR INTERVAL HISTORY <i>(Use additional sheets if necessary.)</i>																																	



REPORT OF MEDICAL HISTORY

(This information is for official and medically confidential use only and will not be released to unauthorized persons.)

Form Approved
OMB No. 0704-0413
Expires Aug 31, 2003

The public reporting burden for this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to Department of Defense, Washington Headquarters Services, Directorate for Information Operations and Reports (0704-0413), 1215 Jefferson Davis Highway, Suite 1204, Arlington, VA 22202-4302. Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.

PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ADDRESS. RETURN COMPLETED FORM AS INDICATED ON PAGE 2.

PRIVACY ACT STATEMENT

AUTHORITY: 10 USC 504, 505, 507, 532, 978, 1201, 1202, and 4346; and E.O. 9397.

PRINCIPAL PURPOSE(S): To obtain medical data for determination of medical fitness for enlistment, induction, appointment and retention for applicants and members of the Armed Forces. The information will also be used for medical boards and separation of Service members from the Armed Forces.

ROUTINE USE(S): None.

DISCLOSURE: Voluntary; however, failure by an applicant to provide the information may result in delay or possible rejection of the individual's application to enter the Armed Forces. For an Armed Forces member, failure to provide the information may result in the individual being placed in a non-deployable status.

WARNING: The information you have given constitutes an official statement. Federal law provides severe penalties (up to 5 years confinement or a \$10,000 fine or both), to anyone making a false statement. If you are selected for enlistment, commission, or entrance into a commissioning program based on a false statement, you can be tried by military courts-martial or meet an administrative board for discharge and could receive a less than honorable discharge that would affect your future.

1. LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)		2. SOCIAL SECURITY NUMBER	3. TODAY'S DATE (YYYYMMDD)
4.a. HOME ADDRESS (Street, Apartment No., City, State, and ZIP Code)		5. EXAMINING LOCATION AND ADDRESS (Include ZIP Code)	
b. HOME TELEPHONE (Include Area Code)			
X ALL APPLICABLE BOXES:			7.a. POSITION (Title, Grade, Component)
6.a. SERVICE	6.b. COMPONENT	6.c. PURPOSE OF EXAMINATION	
<input type="checkbox"/> Army <input type="checkbox"/> Coast Guard	<input type="checkbox"/> Active Duty	<input type="checkbox"/> Enlistment	7.b. USUAL OCCUPATION
<input type="checkbox"/> Navy	<input type="checkbox"/> Reserve	<input type="checkbox"/> Medical Board <input type="checkbox"/> Other (Specify)	
<input type="checkbox"/> Marine Corps	<input type="checkbox"/> National Guard	<input type="checkbox"/> Commission	
<input type="checkbox"/> Air Force		<input type="checkbox"/> Retention	
		<input type="checkbox"/> Separation	
8. CURRENT MEDICATIONS (Prescription and Over-the-counter)		9. ALLERGIES (Including insect bites/stings, foods, medicine or other substance)	

Mark each item "YES" or "NO". Every item marked "YES" must be fully explained in Item 29 on Page 2.

HAVE YOU EVER HAD OR DO YOU NOW HAVE:	YES	NO	12. (Continued)	YES	NO
10.a. Tuberculosis	<input type="radio"/>	<input type="radio"/>	f. Foot trouble (e.g., pain, corns, bunions, etc.)	<input type="radio"/>	<input type="radio"/>
b. Lived with someone who had tuberculosis	<input type="radio"/>	<input type="radio"/>	g. Impaired use of arms, legs, hands, or feet	<input type="radio"/>	<input type="radio"/>
c. Coughed up blood	<input type="radio"/>	<input type="radio"/>	h. Swollen or painful joint(s)	<input type="radio"/>	<input type="radio"/>
d. Asthma or any breathing problems related to exercise, weather, pollens, etc.	<input type="radio"/>	<input type="radio"/>	i. Knee trouble (e.g., locking, giving out, pain or ligament injury, etc.)	<input type="radio"/>	<input type="radio"/>
e. Shortness of breath	<input type="radio"/>	<input type="radio"/>	j. Any knee or foot surgery including arthroscopy or the use of a scope to any bone or joint	<input type="radio"/>	<input type="radio"/>
f. Bronchitis	<input type="radio"/>	<input type="radio"/>	k. Any need to use corrective devices such as prosthetic devices, knee brace(s), back support(s), lifts or orthotics, etc.	<input type="radio"/>	<input type="radio"/>
g. Wheezing or problems with wheezing	<input type="radio"/>	<input type="radio"/>	l. Bone, joint, or other deformity	<input type="radio"/>	<input type="radio"/>
h. Been prescribed or used an inhaler	<input type="radio"/>	<input type="radio"/>	m. Plate(s), screw(s), rod(s) or pin(s) in any bone	<input type="radio"/>	<input type="radio"/>
i. A chronic cough or cough at night	<input type="radio"/>	<input type="radio"/>	n. Broken bone(s) (cracked or fractured)	<input type="radio"/>	<input type="radio"/>
j. Sinusitis	<input type="radio"/>	<input type="radio"/>	13.a. Frequent indigestion or heartburn	<input type="radio"/>	<input type="radio"/>
k. Hay fever	<input type="radio"/>	<input type="radio"/>	b. Stomach, liver, intestinal trouble, or ulcer	<input type="radio"/>	<input type="radio"/>
l. Chronic or frequent colds	<input type="radio"/>	<input type="radio"/>	c. Gall bladder trouble or gallstones	<input type="radio"/>	<input type="radio"/>
11.a. Severe tooth or gum trouble	<input type="radio"/>	<input type="radio"/>	d. Jaundice or hepatitis (liver disease)	<input type="radio"/>	<input type="radio"/>
b. Thyroid trouble or goiter	<input type="radio"/>	<input type="radio"/>	e. Rupture/hernia	<input type="radio"/>	<input type="radio"/>
c. Eye disorder or trouble	<input type="radio"/>	<input type="radio"/>	f. Rectal disease, hemorrhoids or blood from the rectum	<input type="radio"/>	<input type="radio"/>
d. Ear, nose, or throat trouble	<input type="radio"/>	<input type="radio"/>	g. Skin diseases (e.g. acne, eczema, psoriasis, etc.)	<input type="radio"/>	<input type="radio"/>
e. Loss of vision in either eye	<input type="radio"/>	<input type="radio"/>	h. Frequent or painful urination	<input type="radio"/>	<input type="radio"/>
f. Worn contact lenses or glasses	<input type="radio"/>	<input type="radio"/>	i. High or low blood sugar	<input type="radio"/>	<input type="radio"/>
g. A hearing loss or wear a hearing aid	<input type="radio"/>	<input type="radio"/>	j. Kidney stone or blood in urine	<input type="radio"/>	<input type="radio"/>
h. Surgery to correct vision (RK, PRK, LASIK, etc.)	<input type="radio"/>	<input type="radio"/>	k. Sugar or protein in urine	<input type="radio"/>	<input type="radio"/>
12.a. Painful shoulder, elbow or wrist (e.g. pain, dislocation, etc.)	<input type="radio"/>	<input type="radio"/>	l. Sexually transmitted disease (syphilis, gonorrhea, chlamydia, genital warts, herpes, etc.)	<input type="radio"/>	<input type="radio"/>
b. Arthritis, rheumatism, or bursitis	<input type="radio"/>	<input type="radio"/>	14.a. Adverse reaction to serum, food, insect stings or medicine	<input type="radio"/>	<input type="radio"/>
c. Recurrent back pain or any back problem	<input type="radio"/>	<input type="radio"/>	b. Recent unexplained gain or loss of weight	<input type="radio"/>	<input type="radio"/>
d. Numbness or tingling	<input type="radio"/>	<input type="radio"/>	c. Currently in good health (If no, explain in Item 29 on Page 2.)	<input type="radio"/>	<input type="radio"/>
e. Loss of finger or toe	<input type="radio"/>	<input type="radio"/>	d. Tumor, growth, cyst, or cancer	<input type="radio"/>	<input type="radio"/>

LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)		SOCIAL SECURITY NUMBER	
Mark each item "YES" or "NO". Every item marked "YES" must be fully explained in Item 29 below.			
HAVE YOU EVER HAD OR DO YOU NOW HAVE:		YES NO	
15.a. Dizziness or fainting spells		<input type="radio"/> YES <input type="radio"/> NO	
b. Frequent or severe headache		<input type="radio"/> YES <input type="radio"/> NO	
c. A head injury, memory loss or amnesia		<input type="radio"/> YES <input type="radio"/> NO	
d. Paralysis		<input type="radio"/> YES <input type="radio"/> NO	
e. Seizures, convulsions, epilepsy or fits		<input type="radio"/> YES <input type="radio"/> NO	
f. Car, train, sea, or air sickness		<input type="radio"/> YES <input type="radio"/> NO	
g. A period of unconsciousness or concussion		<input type="radio"/> YES <input type="radio"/> NO	
h. Meningitis, encephalitis, or other neurological problems		<input type="radio"/> YES <input type="radio"/> NO	
16.a. Rheumatic fever		<input type="radio"/> YES <input type="radio"/> NO	
b. Prolonged bleeding <i>(as after an injury or tooth extraction, etc.)</i>		<input type="radio"/> YES <input type="radio"/> NO	
c. Pain or pressure in the chest		<input type="radio"/> YES <input type="radio"/> NO	
d. Palpitation, pounding heart or abnormal heartbeat		<input type="radio"/> YES <input type="radio"/> NO	
e. Heart trouble or murmur		<input type="radio"/> YES <input type="radio"/> NO	
f. High or low blood pressure		<input type="radio"/> YES <input type="radio"/> NO	
17.a. Nervous trouble of any sort <i>(anxiety or panic attacks)</i>		<input type="radio"/> YES <input type="radio"/> NO	
b. Habitual stammering or stuttering		<input type="radio"/> YES <input type="radio"/> NO	
c. Loss of memory or amnesia, or neurological symptoms		<input type="radio"/> YES <input type="radio"/> NO	
d. Frequent trouble sleeping		<input type="radio"/> YES <input type="radio"/> NO	
e. Received counseling of any type		<input type="radio"/> YES <input type="radio"/> NO	
f. Depression or excessive worry		<input type="radio"/> YES <input type="radio"/> NO	
g. Been evaluated or treated for a mental condition		<input type="radio"/> YES <input type="radio"/> NO	
h. Attempted suicide		<input type="radio"/> YES <input type="radio"/> NO	
i. Used illegal drugs or abused prescription drugs		<input type="radio"/> YES <input type="radio"/> NO	
18. FEMALES ONLY. Have you ever had or do you now have:			
a. Treatment for a gynecological (female) disorder		<input type="radio"/> YES <input type="radio"/> NO	
b. A change of menstrual pattern		<input type="radio"/> YES <input type="radio"/> NO	
c. Any abnormal PAP smears		<input type="radio"/> YES <input type="radio"/> NO	
d. First day of last menstrual period (YYYYMMDD)			
e. Date of last PAP smear (YYYYMMDD)			
19. Have you been refused employment or been unable to hold a job or stay in school because of:			
a. Sensitivity to chemicals, dust, sunlight, etc.		<input type="radio"/> YES <input type="radio"/> NO	
b. Inability to perform certain motions		<input type="radio"/> YES <input type="radio"/> NO	
c. Inability to stand, sit, kneel, lie down, etc.		<input type="radio"/> YES <input type="radio"/> NO	
d. Other medical reasons <i>(If yes, give reasons.)</i>		<input type="radio"/> YES <input type="radio"/> NO	
20. Have you ever been treated in an Emergency Room? <i>(If yes, for what?)</i>		<input type="radio"/> YES <input type="radio"/> NO	
21. Have you ever been a patient in any type of hospital? <i>(If yes, specify when, where, why, and name of doctor and complete address of hospital.)</i>		<input type="radio"/> YES <input type="radio"/> NO	
22. Have you ever had, or have you been advised to have any operations or surgery? <i>(If yes, describe and give age at which occurred.)</i>		<input type="radio"/> YES <input type="radio"/> NO	
23. Have you ever had any illness or injury other than those already noted? <i>(If yes, specify when, where, and give details.)</i>		<input type="radio"/> YES <input type="radio"/> NO	
24. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? <i>(If yes, give complete address of doctor, hospital, clinic, and details.)</i>		<input type="radio"/> YES <input type="radio"/> NO	
25. Have you ever been rejected for military service for any reason? <i>(If yes, give date and reason for rejection.)</i>		<input type="radio"/> YES <input type="radio"/> NO	
26. Have you ever been discharged from military service for any reason? <i>(If yes, give date, reason, and type of discharge; whether honorable, other than honorable, for unfitness or unsuitability.)</i>		<input type="radio"/> YES <input type="radio"/> NO	
27. Have you ever received, is there pending, or have you ever applied for pension or compensation for any disability or injury? <i>(If yes, specify what kind, granted by whom, and what amount, when, why.)</i>		<input type="radio"/> YES <input type="radio"/> NO	
28. Have you ever been denied life insurance?		<input type="radio"/> YES <input type="radio"/> NO	
29. EXPLANATION OF "YES" ANSWER(S) <i>(Describe answer(s), give date(s) of problem, name of doctor(s) and/or hospital(s), treatment given and current medical status.)</i>			

NOTE: HAND TO THE DOCTOR OR NURSE, OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL PERSONNEL ONLY."

LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)		SOCIAL SECURITY NUMBER
30. EXAMINER'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA <i>(Physician/practitioner shall comment on all positive answers in questions 10 - 29. Physician/practitioner may develop by interview any additional medical history deemed important, and record any significant findings here.)</i>		
a. COMMENTS		
b. TYPED OR PRINTED NAME OF EXAMINER <i>(Last, First, Middle Initial)</i>		c. SIGNATURE
		d. DATE SIGNED <i>(YYYYMMDD)</i>

NSN 7540-01-075-3786

MEDICAL RECORD		EMERGENCY CARE AND TREATMENT (Patient)				LOG NUMBER		TREATMENT FACILITY		
						RECORDS MAINTAINED AT				
PATIENT'S HOME ADDRESS OR DUTY STATION										
STREET ADDRESS						DATE (Day, Month, Year)		TIME		
CITY				STATE		ZIP CODE		TRANSPORTATION TO FACILITY		
SEX	DUTY/LOCAL PHONE		MILITARY STATUS				THIRD PARTY INSURANCE			
	AREA CODE	NUMBER	ITEM	YES	NO	N/A	ITEM	YES	NO	
AGE	HOME PHONE		FLYING STATUS				ADDITIONAL INSURANCE			
		NUMBER	MEDICAL HISTORY OBTAINED FROM		NAME OF INSURANCE COMPANY					
CURRENT MEDICATIONS			INJURY OR OCCUPATIONAL ILLNESS				EMERGENCY ROOM VISIT			
				YES	NO	WHEN (DATE)	DATE LAST VISIT	24 HOUR RETURN <input type="checkbox"/> YES <input type="checkbox"/> NO		
ALLERGIES			IS THIS AN INJURY				WHERE	TETANUS		
			INJURY/SAFETY FORMS HOW				DATE LAST SHOT	COMPLETED INITIAL SERIES <input type="checkbox"/> YES <input type="checkbox"/> NO		
CHIEF COMPLAINT										
CATEGORY OF TREATMENT				VITAL SIGNS						
<input type="checkbox"/> EMERGENT <input type="checkbox"/> URGENT <input type="checkbox"/> NON-URGENT		TIME		TIME						
				B/P						
		INITIALS		PULSE						
				RESP						
				TEMP						
WT										
LAB ORDERS	CBC/DIFF		ABG	PT/PTT	BHCG/URINE/BLOOD/QUANT		X-RAY ORDERS	CXR PA & LAT/ PORTABLE		C-SPINE
	URINE C&S		UA	CHEM:		ACUTE ABDOMEN		LS SPINE		
	BLOOD C&S X					ANKLE R/L		HEAD CT		
ORDERS										
<input type="checkbox"/> PULSE OX			<input type="checkbox"/> MONITOR				<input type="checkbox"/> ECG			
TIME	ORDERS		BY	COMPLETED BY		TIME	PATIENT'S RESPONSE			
DISPOSITION			DISPOSITION QUARTERS/OFF DUTY				PATIENT/DISCHARGE INSTRUCTIONS			
<input type="checkbox"/> HOME <input type="checkbox"/> FULL DUTY MODIFIED DUTY UNTIL			<input type="checkbox"/> 24 HRS. <input type="checkbox"/> 48 HRS. <input type="checkbox"/> 78 HRS. RETURN TO DUTY							
CONDITION UPON RELEASE			ADMIT TO UNIT/SERVICE				REFERRED	TO	WHEN	
<input type="checkbox"/> IMPROVED <input type="checkbox"/> UNCHANGED <input type="checkbox"/> DETERIORATED			TIME OF RELEASE				I have received and understand these instructions. PATIENT'S SIGNATURE			
PATIENT'S IDENTIFICATION (For typed or written entries, give: name-last, first, middle; ID no. (SSN or other); hospital or medical facility)										

EMERGENCY CARE AND TREATMENT (Patient)

MEDICAL RECORD

STANDARD FORM 558 (REV 9-96)

Prescribed by GSA/ICMR

FPMR (41 CFR) 101-11.203(b)(10)

MEDICAL RECORD		EMERGENCY CARE AND TREATMENT (Doctor)				TIME SEEN BY PROVIDER				
TEST RESULTS										
CBC	WBC	SMAC				ABG/PULSE OX		RADIOLOGY	CHECK IF READ BY RADIOLOGIST	<input type="checkbox"/>
	H/H					SUP 02	PH			
	PLT					PCO2	SAT	OTHER	EKG INTERPRETATION	
	PT					U/A	DIP			
APTT		BHCG	ETOH	GLU	MICRO					
PROVIDER HISTORY/PHYSICAL										

SAMPLE FORM

CONSULT WITH	TIME	ACTION	RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP	
			PROVIDER SIGNATURE AND STAMP	
DIAGNOSIS			CODES	

PATIENT'S IDENTIFICATION (For typed or written entries, give: Name-last, first ,middle;
ID no. (SSN or other); hospital or medical facility)

EMERGENCY CARE AND TREATMENT (Doctor)
 MEDICAL RECORD
STANDARD FORM 558 (REV 9-96)
 Prescribed by GSA/ICMR
 FPMR (41 CFR) 101-11.203(b)(10)

MEDICAL RECORD		NARRATIVE SUMMARY (CLINICAL RESUME)	
DATE OF ADMISSION	DATE OF DISCHARGE		NUMBER OF DAYS HOSPITALIZED
<p style="text-align: center;">(Sign and date at end of narrative)</p> <p style="text-align: center; font-size: 48px; color: blue; transform: rotate(-15deg); opacity: 0.5;">SAMPLE FORM</p>			
SIGNATURE OF PHYSICIAN		DATE	IDENTIFICATION NO.
PATIENT'S IDENTIFICATION		REGISTER NO.	
(For typed or written entries give: Name last, first; middle; grade; rank; rate ;hospital or medical facility)		WARD NO.	

NARRATIVE SUMMARY (CLINICAL RESUME)

MEDICAL RECORD
 STANDARD FORM 502 (rev-7-91)
 Prescribed by GSA/ICMR, FIRM
 (41-CFR) 201-9.202.1

Encl. (1) to CHAP 4, COMDTINST M6000.1B

MEDICAL RECORD		CONSULTATION SHEET	
REQUEST			
TO:		FROM: <i>(requesting physician or activity)</i>	DATE OF REQUEST
REASON FOR REQUEST <i>(Complaints and findings)</i>			
PROVISIONAL DIAGNOSIS			
DOCTOR'S SIGNATURE	APPROVED	PLACE OF CONSULTATION <input type="checkbox"/> BEDSIDE <input type="checkbox"/> ON CALL	<input type="checkbox"/> ROUTINE <input type="checkbox"/> TODAY <input type="checkbox"/> 72 HOURS <input type="checkbox"/> EMERGENCY
CONSULTATION REPORT			
RECORD REVIEWED <input type="checkbox"/> YES <input type="checkbox"/> NO PATIENT EXAMINED <input type="checkbox"/> YES <input type="checkbox"/> NO TELEMEDICINE <input type="checkbox"/> YES <input type="checkbox"/> NO			
SAMPLE FORM			
SIGNATURE AND TITLE			DATE
HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT	DEPARTMENT/SERVICE OF PATIENT	
RELATION TO SPONSOR	SPONSOR'S NAME <i>(last, first, middle)</i>	SPONSOR'S ID NUMBER	
PATIENT'S IDENTIFICATION <i>(For typed or written entries, give: Name -last, first, middle; ID No.(SSN or other); Sex; Date of Birth; Rank/Grade)</i>		REGISTER NO.	WARD NO.

CONSULTATION SHEET
MEDICAL RECORD
STANDARD FORM 513 (Rev. 4-98)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

Clinical Record					ELECTROCARDIOGRAPHIC RECORD					Previous ECG <input type="checkbox"/> Yes <input type="checkbox"/> NO	
Clinical Impression					Medication		<input type="checkbox"/> Emergency <input type="checkbox"/> Routine		<input type="checkbox"/> Bedside <input type="checkbox"/> Ambulant		
Age	Sex	Race	Height	B.P.	Signature of Ward Physician				Date		
Rhythm					Axis Deviation			Rates Auric.		Vent.	
Intervals PR QRS QT					P Waves						
QRS Complexes											
RS-T Segment					T Waves						
Unipolar Extremity Leads (<i>specify</i>)											
Precordial Leads (<i>specify</i>)											
Summary, Serial Changes, and Implications:											
(Continue on Reverse)											
No. ECG		Signature of Physician			Patient's Identification No.				Date		
Patient's Identification (For typed or written entries give; Name – Last First, middle; grade, date hospital or medical facility)					Register No.				Ward No.		

Electrocardiographic Records
Standard Form 520
General Services Administration and
Interagency Committee on Medical Records
FPMR 101-11.806-8
October 1975 520-106

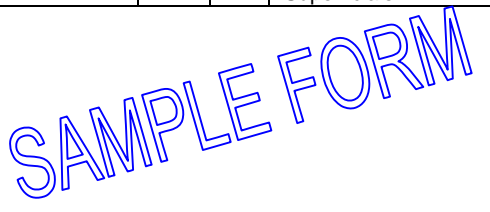
MEDICAL RECORD		TISSUE EXAMINATION	
SPECIMEN SUBMITTED BY			DATE OBTAINED
SPECIMEN			
BRIEF CLINICAL HISTORY <i>(include duration of lesion and rapidity of growth, if a neoplasm)</i>			
PREOPERATIVE DIAGNOSIS			
OPERATIVE FINDINGS			
POSTOPERATIVE DIAGNOSIS		SIGNATURE	
		NAME OF SIGNER	
		TITLE OF SIGNER	
PATHOLOGICAL REPORT			
NAME OF LABORATORY		ACCESSION NO(S)	
GROSS DESCRIPTION, HISTOLOGIC EXAMINATION AND DIAGNOSES			

SAMPLE FORM

SIGNATURE OF PATHOLOGIST		NAME OF PATHOLOGIST		DATE
HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT	DEPARTMENT/SERVICE OF PATIENT		
RELATION TO SPONSOR	SPONSOR'S NAME <i>(Last, first middle)</i>	SPONSOR'S ID NUMBER <i>(SSN or Other)</i>		
PATIENT'S IDENTIFICATION <small>(For typed or written entries, give: Name-last, first, middle; ID no. SSN or other); Sex; Date of Birth; Rank/Grade)</small>		REGISTER NO.	WARD NO.	

TISSUE EXAMINATION
Medical Record

STANDARD FORM 515 (Rev 8-97)
Prescribed by GSA/ICMR FPMR 101-11.203(b)(10)

Medical record		GYNECOLOGIC CYTOLOGY					
Section I – Clinical data to be Completed by Examining Installation							
Date Obtained			LMP First Day			Date Received in Laboratory	
Source of Specimen <input type="checkbox"/> Combined Cervix and Vagina <input type="checkbox"/> Cervix <input type="checkbox"/> Vagina <input type="checkbox"/> Other (Specify)							
Age	Pregnancy <input type="checkbox"/> Yes <input type="checkbox"/> No		Gravida	Para	Previous Abnormal Cytologic Examination <input type="checkbox"/> Yes, Give Date _____ <input type="checkbox"/> No		
Clinical History (Surgery, Drugs, hormones, radiation, etc.)				Physical Examination (Pelvic findings, etc.)			
Specimen Submitted By (Facility)			Signature and title			Submitting Facility Accession Number	
Section II – Cytologic Findings Form Reporting Installation Only							
Name of Laboratory					Accession Number		
Check One	Yes	No	Check One	Yes	No		
Granulocytes			Endocervical Cells			Maturation Index	
Leukocytes						Parabasals	
Trichomonas			Screened By			Intermediates	
Candida						Superficials	
Comments and recommendations							
							
Pathologist's Signature			Title			Date	
Patients Identification (For typed or written entries give; Name – Last first, Middle; grade, date, hospital or medical facility)					Register No.		Ward No.




Standard form 541
Provided by GSA and ICMB

Encl. (1) to CHAP 4, COMDTINST M6000.1B

CLINICAL RECORD		LABORATORY REPORTS	
		ATTACH 3D REPORT ALONG HERE AND ↗ SUCCEEDING ONES ON ABOVE LINES	
		ATTACH 2D REPORT WITH TOP AT THIS LINE ↗	
		ATTACH 1 ST REPORT ALONG LEFT MARGIN WITH TOP AT THIS LINE ↗	
ATTACHING MARGIN			
ATTACH ALL TEST REPORTS TO THIS SHEET			
PATIENT'S IDENTIFICATION (For typed or written entries give: Name - Last, first, middle; grade; date; hospital or medical facility),		REGISTER NO.	WARD NO.

LABORATORY REPORTS

Standard Form 514
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45.505
October 1975 514-108

MEDICAL RECORD	RADIOLOGICAL CONSULTATION REQUESTS/REPORTS
	ATTACH 3D REPORT ALONG HERE  AND SUCCEEDING ONES ON ABOVE LINES
	ATTACH 2D REPORT WITH TOP AT THIS LINE 
ATTACH REPORTS WITHIN THIS MARGIN	ATTACH 1 ST REPORT ALONG LEFT MARGIN WITH TOP AT THIS LINE 

SAMPLE FORM

**RADIOLOGICAL CONSULTATIONS
REQUESTS/REPORTS
STANDARD FORM 519** (Rev. 2-84)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201.45.505
519-11
NSN 7540-00-634-4160

Encl. (1) to CHAP 4, COMDTINST M6000.1B

(THIS FORM IS SUBJECT TO THE
PRIVACY ACT OF 1974 –
Use DD Form 2006.)

EYEWEAR PRESCRIPTION				DATE		ACCOUNT NUMBER				ORDER NUMBER													
TO: (LAB)						FROM:																	
NAME (Last, First)						SSN				GRADE													
ADDRESS/UNIT								PHONE															
ADDRESS CONTINUED								SHIP TO: <input type="checkbox"/> CLINIC <input type="checkbox"/> PATIENT															
CITY, STATE, ZIP																							
AD		RES		NG		RET		OTHER		A		N		AF		MC		CG		PHS		OTHER	
FRAME				EYE				BRIDGE				TEMPLE				COLOR							
DIST				NEAR				LENS				TINT				MATERIAL				PAIR		CASE	
PD																							
SPHERE		CYLINDER		AXIS		DECENTER		H PRISM		H BASE		V PRISM		V BASE									
R																							
L																							
MULTIVISION										LAB USE													
NEAR ADD		SEG HT		TOTAL DECENTER																			
										PRIORITY						TECH INITIALS							
SPECIAL COMMENTS/JUSTIFICATION (* Use this space to specify blocks marked "Other.")																							
PRESCRIBING OFFICER/AUTHORITY												SIGNATURE											
DISTRIBUTION: ORIGINAL – Retained by Lab. COPY 1 – Returned with eyewear. COPY 2 – Entered in health record.																							

DD FORM 771, JUL 96 (EG)

PREVIOUS EDITION IS

Designed using Perform Pro, WHS/DIOR, Aug 96

HEALTH RECORD		IMMUNIZATION RECORD				<i>All entries in ink to be made in block letters</i>		
VACCINATION AGAINST SMALLPOX (Number of previous vaccination scars)								
	DATE	ORIGIN	BATCH NUMBER	REACTION	STATION	PHYSICIAN'S NAME		
1								
2								
3								
4								
5								
6								
YELLOW FEVER VACCINE								
	DATE	ORIGIN	BATCH NUMBER	STATION		PHYSICIAN'S NAME		
1								
2								
3								
TYPHOID VACCINE								
	DATE	DOSE	PHYSICIAN'S NAME			DATE	DOSE	PHYSICIAN'S NAME
1					4			
2					5			
3					6			
TETANUS-DIPHTHERIA TOXOIDS								
	DATE	DOSE	PHYSICIAN'S NAME			DATE	DOSE	PHYSICIAN'S NAME
1					4			
2					5			
3					6			
CHOLERA VACCINE								
	DATE	PHYSICIAN'S NAME			DATE	PHYSICIAN'S NAME		
1				4				7
2				5				8
3				6				9

PATIENTS IDENTIFICATION (Mechanically Imprint, Type or Print):

▶ Patient's Name – last, first, middle initial;
Sex; age or Year Of Birth; Relationship to Sponsor;
Component/Status; Department/Service.

▶ Sponsor's Name – last, first, middle initial;
Rank/Grade; SSN or Identification Number;
Organization.

IMMUNIZATION RECORD
Standard Form 601 – October 1975 (Rev.)
General Services Administration & Interagency
Committee on Medical Records
FIRMR (41 CFR) 201-45.505

ORAL POLIOVIRUS VACCINE							
	DATE	DOSE	PHYSICIAN'S NAME		DATE	DOSE	PHYSICIAN'S NAME
1				3			
2				4			

INFLUENZA VACCINE							
	DATE	DOSE	PHYSICIAN'S NAME		DATE	DOSE	PHYSICIAN'S NAME
1				3			
2				4			

INFLUENZA VACCINE									
	DATE	TYPE	DOSE	PHYSICIAN'S NAME		DATE	TYPE	DOSE	PHYSICIAN'S NAME
1									
2									
3					7				
4					8				

SENSITIVITIES TEST <i>(Tuberculin, etc.)</i>						
	DATE	TYPE	DOSE	ROUTE	RESULTS	PHYSICIAN'S NAME
1						
2						
3						
4						
5						

REMARKS:

THIS RECORD IS ISSUED IN ACCORDANCE WITH ARTICLE 99, WHO SANITARY REGULATION NO 2.

HEALTH RECORD				SYPHILIS RECORD		
SECTION 1. – HISTORY OF PAST VENEREAL INFECTIONS OR TREATMENTS						
DATE	DISEASE <i>(Give stage)</i>	PRIOR TO MIL. SERVICE		TREATMENT <i>(Give type, amount and dates)</i>	TREATING AGENCY	PLACE
		YES	NO			
1						
2						
3						
4						
SECTION II = HISTORY OF PRESENT INFECTION						
CAME TO MEDIAL ATTENTION BY: VOLUNTARY <input type="checkbox"/> CONTACT REPORT <input type="checkbox"/> PHYSICAL INSPECTION <input type="checkbox"/> FOOD HANDLER <input type="checkbox"/>						
INCIDENT TO HOSPITALIZATION		PREMARITAL <input type="checkbox"/>		PRENATAL <input type="checkbox"/>	OTHER <i>(Specify)</i> <input type="checkbox"/>	
DATES: ONSET SYMPTOMS				REQUESTED TREATMENT	DIAGNOSIS ESTABLISHED	
DIAGNOSIS <i>(Include stage and diagnosis No.)</i>				DIAGNOSTIC CRITERIA <i>(Enter results of test)</i>		
LIST VD CONTACT FORM SERIAL NOS.						
CLINICAL DATA <i>(Including chief complaint, physical findings – eye, cardiovascular and nervous system, even in early syphilis)</i> <div style="font-size: 4em; color: blue; opacity: 0.5; transform: rotate(-15deg); pointer-events: none;">SAMPLE FORM</div>						
RECOMMENDED TREATMENT AND FOLLOW-UP				SIGNATURE OF PHYSICIAN		DATE
HAVE BEEN INFORMED BY THE MEDICAL OFFICER THAT I HAVE BEEN DIAGNOSED AS HAVING SYPHILIS AS INDICATED ABOVE; THE NATURE OF THIS DISEASE HAS BEEN EXPLAINED TO ME; I UNDERSTAND THAT MY COOPERATION IS NECESSARY IN THE TREATMENT AND PROLONGED OBSERVATION <i>(including certain prescribed tests)</i> FOR THE CARE OF THIS DISEASE.				SIGNATURE OF PATIENT AND DATE		
SECTION III. - TREATMENT						
	TREATMENT	DATE STARTED	DATE ENDED	SIGNATURE OF PHYSICIAN		
1						
2						
3						
4						

PATIENT'S IDENTIFICATION *(Mechanically Imprint, Type or Print):*



Patient's Name – last, first, middle initial;
Sex; age or Year Of Birth; Relationship to Sponsor;
Component/Status; Department/Service.



Sponsor's Name – last, first, middle initial;
Rank/Grade; SSN or Identification Number;
Organization.

SYPHILIS RECORD

Standard Form 602 – March – 1975 (Rev.)
General Services Administration &
Interagency Comm on Medical Records

SECTION IV. – CUMULATIVE LABORATORY SUMMARY									
RESULTS OF DARKFIELD EXAMINATION									
	DATE	RESULTS	SOURCE OF SPECIMEN	LABORATORY	NAME OF CONFIRMING OFFICER				
1									
2									
RESULTS OF SEROLOGICAL TESTS FOR SYPHILIS									
	DATE	TYPE	RESULT (Include titer value)	LABORATORY		DATE	TYPE	RESULT (Include Titer value)	LABORATORY
1					5				
2					6				
3					7				
4					8				
FLUORESCENT ANTIBODY TESTS									
	DATE								
1									
2									
RESULTS OF SPINAL FLUID EXAMINATION									
	DATE	CELLS	TOTAL PROTEIN	SEROLOGICAL TEST (Including titer)			LABORATORY WHERE DONE		
1									
2									
SECTION V. – EVALUATION OF THERAPY									
	DATE	FACILITY WHERE EVALUATED	RESULT		DATE OF RETREATMENT	PHYSICIAN'S SIGNATURE			
			Satisfactory	UNSATISFACTORY					
1									
2									
3									
4									
*Satisfactory result cannot be reported without normal spinal fluid findings.									
**Specify: Infectious Relapse: Sero-Relapse, Neuro-Relapse, Incomplete data on Spinal Fluid, Other (Specify)									
REASON FOR INADEQUATE FOLLOW-UP (Date, place and type of separation – Give authority for discharge)									
PATIENT'S HOME ADDRESS ON SEPARATION					CIVILIAN HEALTH DEPT. TO WHICH CASE RESUME WAS SENT				
REINFECTION (Give date new record was opened)									
REMARKS									
SECTION VI. – MEDICAL OFFICER CLOSING THIS RECORD									
NAME (Typed or printed)			SIGNATURE		STATION		DATE		
SECTION VII. – MEDICAL OFFICER SENDING ABSTRACT TO VETERAN'S ADMINISTRATION ON DISCHARGE									
NAME (Typed or printed)			SIGNATURE		STATION		DATE		

[illegible]

Encl. (1) to CHAP 4, COMDTINST M6000.1B

[illegible]

AGREEMENT/DISAGREEMENT

I agree ☐ (or) do not agree ☐ that at the time of separation:

(2) I am reasonably able to perform my current duties, or

(2) I have a high expectation of recovery in the near term from illness, injury or surgical procedure such that I would again be able to perform my usual duties.

Date	Grade/Rate	Signature of Member
------	------------	---------------------

TERMINATION OF HEALTH RECORD

Remarks

Impairments, which have been documented in your health record, including any separation exam, while establishing service connection, do not in themselves indicate a disability. To receive disability benefits from the Coast Guard, you must be found unfit to perform your assigned duties through the physical disability evaluation system before you are separated.

After you are separated, any claims for disability benefits must be submitted to the Department of Veterans Affairs. If you have questions about certain benefits to which you might be entitled you should contact the DVA Regional Office nearest your home as soon as practical.

I have read the above statements and acknowledge receipt of a copy of the following:

1. CG-4057, Chronological record of Service.
2. SF-88 report of Medical Examination date_____ (if performed).
3. PHS-731, International Certificate of Vaccination.
4. DD Form 2766, Adult Preventive and Chronic Care Flowsheet.

Date	Grade/Rate	Signature of Member
------	------------	---------------------

COMMAND CERTIFICATION

Health record terminated this date by reason of_____

In accordance with Chapter 4, Medical Manual, COMDTINST M6000.1 (series)

Date	Title	Signature
------	-------	-----------

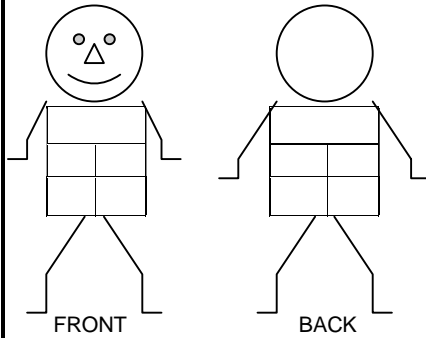
Encl. (1) to CHAP 4, COMDTINST M6000.1B

NAVMED – 6150/2 (REV 8-70)			SPECIAL DUTY MEDICAL ABSTRACT (NAVMED 6150/2)		
Health Record			Special Duty Medical Abstract		
Summary of Physical Examination for Special Duty					
Date	Place	Purpose	Result – Recommendation (<i>Defects Reverse</i>)	BUMED Action	Sig. Of M.D.
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
Suspension From Special Duty					
Date (<i>From</i>) (<i>To</i>)		No. of Days	Reason for Suspension	Signature of Medical Officer	
1.					
2.					
3.					
4.					
5.					
6.					
7.					
Periodic Special Duty Requalification					
Date	Signature of . O.		Date	Signature of M.O.	
Name (Last) (First) (Middle)			Grade/Rate		Service/Soc. Sec.
					Organization

SPECIAL DUTY MEDICAL ABSTRACT (NAVMED 6150/2)

Altitude Training, Air Compression and Oxygen Tolerance			
Date	Station	Type of Run – Reaction	Signature or M.O.
1.			
2.			
3.			
4.			
5.			
Explosive Decompression Training			
Date	Station	Altitudes - Reaction	Signature or M.O.
1.			
2.			
Submarine Escape and Diving Training			
Date	Station	Type of Run - Reaction	Signature or M.O.
1.			
2.			
3.			
4.			
5.			
Visual and Disorientation Training			
Date	Station	Type of Training	Signature or M.O.
1.			
2.			
3.			
4.			
Centrifuge and Ejection Seat Training			
Date	Station	Type of run – Reaction	Signature or M.O.
1.			
2.			
Remarks			

EMERGENCY MEDICAL TREATMENT REPORT

VICTIM IDENTIFICATION	1. Name _____		RESCUER INFORMATION	10. Name: _____ 11. Level: _____																																																																																											
	2. Sex (check one) male _____ female _____			12. Unit: _____																																																																																											
	3. Estimated age yrs _____ mos _____			13. OPFAC #: _____																																																																																											
				14. Rescue Vehicle: _____																																																																																											
				15. Receiving Unit: _____																																																																																											
				16. Time Patient Transferred: _____																																																																																											
DESCRIPTION OF INCIDENT	4. Date: _____		5. Type of incident: _____		NATURE OF EMERGENCY / MECHANISM OF INJURY																																																																																										
	6. Time on Scene: _____		a) marine _____																																																																																												
	7. Time of incident: _____		b) aviation _____																																																																																												
			c) Industrial _____																																																																																												
	8. Location: _____		d) auto _____																																																																																												
			e) domestic _____																																																																																												
			f) other _____																																																																																												
OBSERVATION OF VICTIM	 <p>FRONT BACK</p> <p>H – hemorrhage F – fracture L – laceration B – burns S – soft tissue injury O2 Liters _____</p>		TREATMENT (CIRCLE AS NEEDED) – DRESSING 2 - TX SPLINT 3 - SPLINT 4 - C/COLLAR 5 - BACK BOARD 6 - TOURNIQUET 7 - CPR 8 - AIRWAY 9 - OXYGEN 10 - MAST 11 - MILLER B/B		MEDICATIONS: ALLERGIES MEDICAL HISTORY / COMMENTS / ETC. (include additional vitals, oxygen, fluids, etc.)																																																																																										
	SKIN (Circle appropriate number of numbers) 1 – normal 4 – cyanotic 7 – cool 2 – pale/ashen 5 – dry 8 – warm 3 – flushed 6 – moist 9 – hot																																																																																														
VITAL SIGNS	<table border="1"> <thead> <tr> <th>TIME</th> <th></th> <th></th> <th></th> <th></th> </tr> </thead> <tbody> <tr> <td>OBSERVED</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Alert</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Responds to Verbal</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Responds to Pain</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Uncon/Unresponsive</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Peri</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Unequal</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Nonreactive</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Dilated</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Pinpoint</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Rate (Numeric)</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Strong</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Weak</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Rate (Numeric)</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Regular</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Shallow</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Labored</td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>					TIME					OBSERVED					Alert					Responds to Verbal					Responds to Pain					Uncon/Unresponsive					Peri					Unequal					Nonreactive					Dilated					Pinpoint					Rate (Numeric)					Strong					Weak					Rate (Numeric)					Regular					Shallow					Labored				
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DEPT. OF TRANSPORTATION., USCG CG-5214 (Rev. 10-88)

PATIENT COPY

Previous Edition May be Used

REQUEST FOR MEDICAL/DENTAL RECORD OR INFORMATION		REQUESTING ACTIVITY Complete Items 1 through 10 (Except 8b); also Complete Item 19. ADDRESSEE — Complete Items 8b, 11 to 14 or 15 to 18, as appropriate, Final referrer shall return to requester.	Date
1. PATIENT (Last Name – First Name – Middle Name)		3. STATUS <input type="checkbox"/> MILITARY <input type="checkbox"/> VA BENEFICIARY	
2. ORGANIZATION AND PLACE OF TREATMENT		<input type="checkbox"/> DEPENDENT <input type="checkbox"/> FEDERAL EMPLOYEE	
		<input type="checkbox"/> OTHER (Specify)	
		3a. NAME OF SPONSOR (If dependent)	
4. TO (Include ZIP Code)		5. IDENTIFYING INFORMATION	
<div style="border: 1px solid black; width: 100px; height: 100px; margin: 0 auto;"></div>		a. SERVICE NUMBER	
		b. GRADE/RATE	
		c. SOCIAL SECURITY ACCOUNT NO.	
		d. VA CLAIM NUMBER	
		e. DATE OF BIRTH (If federal employee)	
6. DATES OF TREATMENT		7. DISEASE OR INJURY	
8. a. RECORDS REQUESTED MIL VA <input type="checkbox"/> <input type="checkbox"/> CLINICAL <input type="checkbox"/> <input type="checkbox"/> OUTPATIENT <input type="checkbox"/> HEALTH RECORD <input type="checkbox"/> <input type="checkbox"/> DENTAL RECORD <input type="checkbox"/> <input type="checkbox"/> X-RAY <input type="checkbox"/> MEDICAL REPORT CARDS, EMERGENCY MEDICAL TAGS, FIELD MEDICAL CARDS <input type="checkbox"/> ABSTRACT OF RATING SHEET <input type="checkbox"/> <input type="checkbox"/> REPORT OF PHYSICAL EXAMINATION <input type="checkbox"/> ALL AVAILABLE RECORDS (Except X-rays unless specifically requested) <input type="checkbox"/> <input type="checkbox"/> OTHERS (List under remarks)		b. RECORDS FORWARDED MIL VA <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
		9. REMARKS	
		10. SIGNATURE	
REPLY/REFERRAL			
11. TO:		12. REMARKS	
13. SIGNATURE		<input type="checkbox"/> RECORDS CHECKED IN 8B FORWARDED. <input type="checkbox"/> NO RECORDS FOUND FOR PATIENT DURING ABOVE PERIOD. <input type="checkbox"/> MORE INFORMATION NEEDED.	
14. DATE			
REPLY/SECOND REFERRAL			
15. TO:		16. REMARKS	
17. SIGNATURE		<input type="checkbox"/> RECORDS CHECKED IN 8B FORWARDED. <input type="checkbox"/> NO RECORDS FOUND FOR PATIENT DURING ABOVE PERIOD. <input type="checkbox"/> MORE INFORMATION NEEDED.	
18. DATE			
19. RETURN TO: (Include ZIP Code)			
<div style="border: 1px solid black; width: 100px; height: 100px; margin: 0 auto;"></div>		REQUESTING ACTIVITY WILL ENTER COMPLETE ADDRESS TO WHICH RECORDS OR FINAL REPLY SHOULD BE MAILED.	

U. S. COAST GUARD

DENTAL RECORD

PRIVACY ACT STATEMENT: HEALTH CARE RECORDS

- AUTHORITY FOR COLLECTION OF INFORMATION INCLUDING SOCIAL SECURITY NUMBER (SSN):**
Section 632 of Title 14 United States Code and Sections 1071-1087, Title 10 United States code, Executive Order 9397.
- PRINCIPAL PURPOSES FOR WHICH INFORMATION IS TO BE USED:**
The purpose for requesting information is to assist medical personnel in developing records to facilitate and document your health condition in order to provide health care and to provide a complete account of such care rendered, including diagnosis, treatment, and end result. The social Security Number (SSN) necessary to identify the person and records.
- ROUTINE USES:**
This information may be used to plan and coordinate health care. It may be used to provide medical treatment, conduct research, teach, compile statistical data, determine suitability of persons for service or assignment, implement preventive health and communicative disease control program; adjudicate claims and determine benefits; evaluate care rendered; determine professional certification of patients to other Federal, State and local agencies upon request in the pursuit of their official duties; and report medical conditions required by law to federal, State and local agencies. It may be used for other lawful purposes including law enforcement and litigation.
- The above Privacy Act Statement applies to all requests for personal information made by medical treatment personnel or for medical treatment purposes. Failure to provide the requested information for these medical records may result in an inability of Coast Guard medical personnel to afford treatment.
- No information may be divulged from this record except to persons properly and directly concerned. Questionable cases will be referred to the Commanding Officer for decision.

LAST NAME	FIRST NAME	MIDDLE NAME	SOCIAL SECURITY NUMBER		DATE OF BIRTH (DAY, MO, YR)		
GRADE OR RATE	CHANGES IN GRADE OR RATE			BLOOD TYPE (Check one)			
				<input type="checkbox"/> O	<input type="checkbox"/> A	<input type="checkbox"/> B	<input type="checkbox"/> AB
				RH FACTOR (Check one)			
				<input type="checkbox"/> POSITIVE			<input type="checkbox"/> NEGATIVE

DRUG SENSITIVITY
SPECIFIC DRUG(S)

ATTACH TO FRONT OF CHART JACKET

DEPT OF TRANSP. USCG CG 3443-2

DENTAL HEALTH QUESTIONNAIRE				Personal Data - Privacy Act of 1974			
ARE YOU IN FLIGHT STATUS? . . . YES <input type="checkbox"/> NO <input type="checkbox"/>				OCCUPATION/JOB: _____			
ARE YOU PRESENTLY ILL OR UNDER THE CARE OF A PHYSICIAN? . . . YES <input type="checkbox"/> NO <input type="checkbox"/>							
IF YES, PLEASE DESCRIBE: _____							
ALLERGIES (including medication, Latex, jewelry, metal, etc.): _____							
CURRENT MEDICATIONS: _____ (including aspirin, over-the-counter medications, etc.): _____							
HISTORY OF HOSPITALIZATIONS: _____							
ANY FAMILY HISTORY OF: Heart Disease <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Seizures <input type="checkbox"/>							
HAVE YOU EVER HAD OR DO YOU NOW HAVE:							
	Yes	No	Don't Know		Yes	No	Don't Know
Epilepsy or Seizures				Hemophilia			
Fainting or dizziness				Bruise or bleed easily			
Anxiety reaction				Heart problems/Angina			
Stroke				Hypertension			
Glaucoma				Rheumatic fever			
Cold Sores (Herpes)				Heart murmur			
Persistent cough				Mitral valve prolapse			
Emphysema				Congenital heart lesions			
TB/PPD positive				Heart surgery			
Asthma				Prosthetic heart valve			
Hay Fever				Pacemaker			
Sinus problems				Blood transfusions			
Anemia				Liver disease			
Sickle cell disease				Yellow jaundice			
G-6-PD deficiency				Hepatitis - type: _____			
				Ulcers			
				Kidney problems			
				Venereal disease			
				Diabetes			
				Thyroid disease			
				HIV/AIDS			
				Arthritis			
				Painful joints (incl. jaw)			
				Prosthetic joint			
				Hives			
				Steroid medication			
				Drug addiction			
				Alcoholism			
				Unexplained weight change			
				Cancer/radiation therapy			
HAVE YOU EVER BEEN TOLD THAT YOU SHOULD NOT DONATE BLOOD? -----							
HAVE YOU EVER BEEN TOLD THAT YOU NEED ANTIBIOTICS BEFORE DENTAL TREATMENT? -----							
FEMALES: Are you taking birth control pills? -----							
Are you or might you be pregnant? Estimated delivery: _____							
DO YOU HAVE ANY DISEASE, CONDITION, OR PROBLEM NOT LISTED ABOVE? Please describe: _____							

Patient's signature						Date	
SUMMARY OF PERTINENT FINDINGS / RECOMMENDED TREATMENT MODIFICATIONS (Dentist's use only) B/P: _____							

WELLNESS SCREEN:							
Tobacco use _____		Exercise _____		Diet/nutrition _____			
Alcohol use _____		Stress _____		Seat belt use _____			
Dental Officer's Signature						Date	
PATIENT'S IDENTIFICATION		PATIENT'S NAME (Last, First, MI)				SEX	
		DATE OF BIRTH		RELATIONSHIP TO SPONSOR		SERVICE	
		SPONSOR'S NAME				RANK/GRADE	
		SSN		ORGANIZATION/COMMAND			
		PHONE #: DAY		EVENING			

DEPT. OF TRANSP., USCG, CG-5605 (4-96)

GENERAL SERVICES ADMINISTRAT.
INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45.505

[illegible]

NSN 7540-00-634-4179

DENTAL

Standard Form 608

603-104

[illegible]

Personal data - Privacy Act of 1974

Bleeding/purulence (+)

Attachment level CEJ to BP

Pocket depths FM to BP

Mark (w/ 3/4 crown, and pontics in blue)

Purification invasion

Grade 1 ▲

Grade 2 ▲

Grade 3 ▲

Record on Occlusal Outlines

Mobility (1,2,3)

Poor contact

Open contact

Food impaction

Caries and faulty restorations outlined in red

Pocket depths FGM to BP

Attachment level CEJ to BP

Bleeding/purulence (+)

Bleeding/purulence (+)

Attachment level CEJ to BP

Pocket depths FGM to BP

KEY

Horiz. lines = 2mm

FGM = free gingival margin

BP = base of pocket

Draw FGM with continuous blue line relative to CEJ

Mark pocket area in red on root surface

Draw mucogingival junction as black continuous line

Block out missing teeth and/or roots

Pocket depths FGM to BP

Attachment level CEJ to BP

Bleeding/purulence (+)

PLACE OF EXAMINATION

EXAMINER

DATE

PATIENT IDENTIFICATION

SEX

GRADE, RATE, OR POSITION

ORGANIZATION/UNIT

COMPONENT OR BRANCH

PHONE: (W)

(H)

PATIENT'S LAST NAME - FIRST NAME - MIDDLE NAME

DATE OF BIRTH (Day-Month-Year)

SOCIAL SECURITY NO.

NAVJAG 6660/2 (3/90)

PERIODONTAL CHART

Patient's Name: _____	SSN: _____						
Chief Complaint: _____							
Pertinent Med Dent Hx: <table border="1" style="float: right; margin-left: 20px;"> <tr> <td style="padding: 2px;">Age</td> <td style="padding: 2px;">Sex</td> <td style="padding: 2px;">Race</td> <td style="padding: 2px;">HT</td> <td style="padding: 2px;">WT</td> <td style="padding: 2px;">BP</td> </tr> </table>		Age	Sex	Race	HT	WT	BP
Age	Sex	Race	HT	WT	BP		
Extraoral Findings: _____							
Intraoral Findings: _____							
Periodontal Findings: _____							
Occlusion: _____							
Pediographic Assesment: _____							
Etiology/Contributing Factors: _____							
Diagnosis: _____							
Prognosis (1-5 years) (Circle One): Good Fair Poor Hopeless							
Overall Individual: _____							
Tentative Treatment Plan: _____ _____ _____							

LAST NAME	FIRST NAME	MIDDLE NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER (OPTIONAL)
-----------	------------	-------------	---------------	-----------------------------------

U.S. Coast Guard

CLINICAL RECORD

PRIVACY ACT STATEMENT; HEALTH CARE RECORDS

STATUS

- DEPENDENT ☐
- RETIREE ☐
- USCG ☐
- USPHS ☐
- USN ☐
- USMC ☐
- USAF ☐
- USA ☐

CIVILIAN EMPLOYEE ☐

OTHER ☐ SPECIFY _____

OCCUPATIONAL MONITORING ☐ SPECIFY _____

- AUTHORITY FOR COLLECTION OF INFORMATION INCLUDING SOCIAL SECURITY NUMBER (SSN):**
Section 632 of Title 14, United States Code and Sections 1071-1087, Title 10 United States Code, Executive Order 9397 and Title 5 United States Code Section 7901.
- PRINCIPAL PURPOSES FOR WHICH INFORMATION IS TO BE USED:**
The purpose for requesting personal information is to assist medical personnel in developing records to facilitate and document your health condition in order to provide health care and to provide a complete account of such care rendered, including diagnosis, treatment, and end result. The Social Security Number (SSN) is not mandatory; however it is desirable for identification and recall of records.
- ROUTINE USES:** The information may be used to plan and coordinate health care. It may be used to provide medical treatment; conduct research; teach; compile statistical data; implement preventive health and communicative disease control programs; adjudicate claims and determine benefits; evaluate care rendered; determine professional certification and hospital accreditation; conduct authorized investigations; provide physical qualifications of patients to other Federal, State and local agencies upon request in the pursuit of their official duties; and report medical conditions required by law to Federal, State and local agencies. It may be used for other lawful purposes including law enforcement and litigation.
- The above Privacy Act Statement applies to all requests for personal information made by medical treatment personnel or for medical treatment purposes. Failure to provide the requested information for these medical records may result in an inability of Coast Guard medical personnel to afford treatment.
- No information may be divulged from this record except to persons properly and directly concerned. Questionable cases will be referred to the Commanding Officer for decision.

MED-ALERT ☐

DEPT. OF TRANSP., USCG, CG-3443-1 (10-77)

MEDICAL RECORD	REQUEST FOR ADMINISTRATION OF ANESTHESIA AND FOR PERFORMANCE OF OPERATIONS AND OTHER PROCEDURES	
A. IDENTIFICATION		
1. OPERATION OR PROCEDURE		
B. STATEMENT OF REQUEST		
<p>1. The nature and purpose of the operation or procedure, possible alternative methods of treatment, the risks involved, and the possibility of complications have been fully explained to me. I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure. I understand the nature of the operation or procedure to be _____</p> <p style="text-align: center;"><small>(Description of operation or procedure in layman's language)</small></p> <p>_____</p> <p>_____</p> <p>which is to be performed by or under the direction of Dr. _____</p> <p>2. I request the performance of the above-named operation or procedure and of such additional operations or procedures as are found to be necessary or desirable, in the judgment of the professional staff of the below-named medical facility, during the course of the above-named operation or procedure.</p> <p>3. I request the administration of such anesthesia as may be considered necessary or advisable in the judgment of the professional staff of the below-named medical facility.</p> <p>4. Exceptions to surgery or anesthesia, if any, are: _____</p> <p style="text-align: center;"><small>(If "none", so state)</small></p> <p>5. I request the disposal by authorities of the below-named medical facility of any tissues or parts which it may be necessary to remove.</p> <p>6. I understand that photographs and movies may be taken of this operation, and that they may be viewed by various personnel undergoing training or indoctrination at this or other facilities. I consent to the taking of such pictures and observation of the operation by authorized personnel, subject to the following conditions:</p> <p style="margin-left: 40px;">a. The name of the patient and his/her family is not used to identify said pictures.</p> <p style="margin-left: 40px;">b. Said pictures be used only for purposes of medical/dental study or research.</p> <p style="text-align: center;"><small>(Cross out any parts above which are not appropriate)</small></p>		
C. SIGNATURES		
<small>(Appropriate items in Parts A and B must be completed before signing)</small>		
1. COUNSELING PHYSICIAN/DENTIST: I have counseled this patient as to the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above.		
_____ <small>(Signature of Counseling Physician/Dentist)</small>		
2. PATIENT: I understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.		
_____ <small>(Signature of Witness, excluding members of operating team)</small>	_____ <small>(Signature of Patient)</small>	_____ <small>(Date and Time)</small>
3. SPONSOR OR GUARDIAN: (When patient is a minor or unable to give consent) I, _____		
sponsor/guardian of _____ understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.		
_____ <small>(Signature of Witness, excluding members of operating team)</small>	_____ <small>(Signature of Sponsor/Legal Guardian)</small>	_____ <small>(Date and Time)</small>
PATIENT'S IDENTIFICATION <small>(For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)</small>	REGISTER NO. <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	WARD NO. <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

STANDARD FORM 522 (Rev. 10-76)
 General Services Administration &
 Interagency Comm. on Medical Records
 FPMR 101-11.806-8
 522-109

NSN 7540-00-634-4165

Standard Form 66 D
April 1985
U.S. Office of Personnel Management
FPM Supplement 293-31
66-501

EMPLOYEE MEDICAL FOLDER

CAUTION MEDICAL RECORD—RESTRICTED USAGE

1. Your use of the contents of this folder must be in accordance with the instructions in The Guide to Personnel Record Keeping.
2. You must safeguard this folder and its contents while it is in your possession.
3. You are required to keep this folder in a locked place when it is not in use.
4. You are normally prohibited from disclosing the contents of this folder to anyone; exceptions are those officials of your agency demonstrating an official need for the record and those other disclosures permitted by the Privacy Act of 1974 (5 U.S.C. 552a).
5. After use, promptly return this folder to the employee responsible for its filing.
6. Willful violations of these requirements are subject to criminal penalties (5 U.S.C. 552a(i)).

Place label between lines.
Type information on label
as shown.

SSN: Name (Last, First, M.I.) DOB:

NSN 7540-01-209-4939
For Label Use:
NSN 7530-00-577-4376 (cut sheet) or
NSN 7530-00-082-2661 (marginally punched)

GPO : 1985 O 460-496 (22)

INPATIENT MEDICAL RECORD COVER SHEET

(See Privacy Act Statement on Reverse)

Name: _____ SSN: _____ Rank/Rate: _____
Last, First, MI

Unit: _____

Date of Birth: ____/____/____ Religon: _____
YY MM DD

Home Address: _____

Next of Kin: _____ Relationship: _____

Address: _____ Phone #: _____
_____Previous Admission: ☐ Yes ☐ No If yes, Date: ____/____/____
YY MM DDDate of Present Admission: ____/____/____ Time: _____ Hours
YY MM DD

Provisional Diagnosis

1. _____
2. _____
3. _____

Provisional Diagnosis

1. _____
2. _____
3. _____

Date of Discharge: ____/____/____ Time: _____ Hours
YY MM DD**DISPOSITION**Duty Status: ☐ FFD ☐ NFFD ☐ FFLD Restrictions: _____

Activity Restrictions: _____

Diet: _____

Medications: _____

Follow-up Appointment(s): _____

Admitting Medical Officer**Discharging Medical Officer**Time Unit Notified: ____/____/____ Time: _____ Hours
YY MM DD

Name of Staff Member Notifying: _____

Name of Person at Unit Receiving Call: _____
Name and Rank/Rate

PRIVACY ACT STATEMENT

In accordance with 5 USC 552a (e)(3), the following applies to persons providing personal information to the U.S. Coast Guard.

1. Section 632, Title 14 USC, § 1071 – 1087. Title 10 USC, and Executive Order 9397 authorizes collection and application of this information.

2. The principal purpose for which this information is intended is to assist medical personnel in developing records to facilitate and document your health condition(s), in order to provide a complete account of care rendered, including diagnosis, treatment, and results. The social security number is necessary to identify the person and records. Family information is required for notification of next of kin in the unlikely event of an emergency.

3. The routine use of this information is for review by attending medical officers and for future reference in rendering health care.

4. Disclosure of this information is voluntary. However, failure to provide the requested information may result in an inability of the Coast Guard medical personnel to deliver comprehensive treatment.

Please note the following and indicate your wishes:

I DO / DO NOT GIVE PERMISSION FOR THE ATTENDING MEDICAL OFFICER AND THE DISPENSARY STAFF TO DISCUSS MY MEDICAL CONDITION OR THE SITUATION OF MY ADMISSION WITH MY PARENTS OR LEGAL GUARDIANS, UPON MY REQUEST.

Signature

Date

Witness

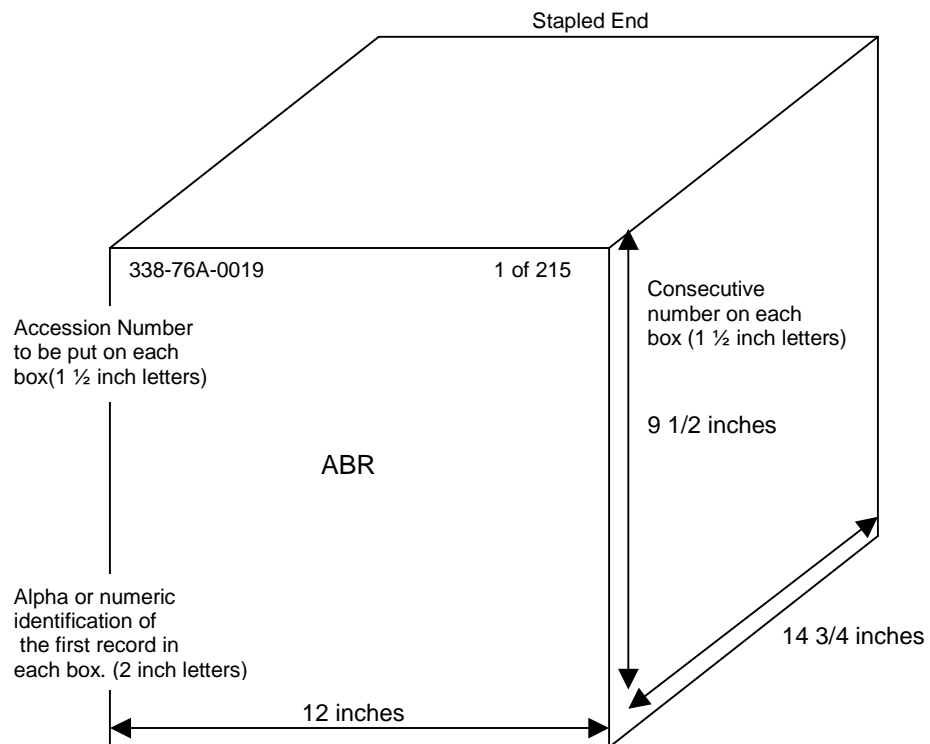
PERSONNEL AUTHORIZED SEPARATE RATIONS

I understand that this facility provides three meals daily for all patients. Further, persons authorized to mess separately will be required to make repayments for meals consumed during their stay.

I have read and understand the statement about separate rations.

Signature

Date



25				
28	13			
31	16			
34	19			
	22			
		338-86-0000 1/36 A-Ba	338-86-0000 2/36 Ba-Ca	338-86-0000 3/36 Ce-Do
		338-86-0000 4/36 Du-Fa	338-86-0000 5/36 Fe-Go	338-86-0000 6/36 Gu-Hab
		338-86-0000 7/36 Hac-Il	338-86-0000 8/36 Im-ja	338-86-0000 9/36 Je-Jum
		338-86-0000 10/36 Jun-Ka	338-86-0000 11/36 Ke-La	338-86-0000 12/36 Le-Lu

INSTRUCTIONS

NURSE: Retain a copy and send to Pharmacy after each order is written.

[illegible]

If needed, continue on Page 2.

PATIENT'S IDENTIFICATION				REGISTER NO.	WARD NO.
--------------------------	--	--	--	--------------	----------

DOCTOR'S ORDERS

STANDARD FORM 508 (Rev. 10-7)
Prescribed by GSA and ICMR
FPMR 101-11 806-8
508-110

Clinical Record		PHYSICAL EXAMINATION					
Date of Exam	Height	Weight			Temperature	Pulse	Blood Pressure
		Average	Maximum	Present			

Instructions: Describe (1) General Appearance and Mental Status; (2) Head and Neck (General); (3) Eyes; (4) Ears; (5) Nose; (6) Mouth; (7) Throat; (8) Teeth; (9) Chest (General); (10) Breast; (11) Lungs; (12) Cardiovascular; (13) Abdomen; (14) Hernia; (15) Genitalia; (16) Pelvic; (17) Rectal; (18) Prostate; (19) Back; (20) Extremities; (21) Neurological; (22) Skin; (23) Lymphatics.

SAMPLE FORM

(Continue reverses side)					
RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)	
	LAST	First	MI		
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY		RECORDS MAINTAINED AT		
PATIENT'S IDENTIFICATION (For typed or written entries give: Name-Last First, Middle; grade; date; hospital or medical facility)				REGISTER NO	WARD NO

PHYSICAL EXAMINATION RECORD
Standard Form 506 (Rev 2-99)
Prescribed by GSA/ICMR (41 CFR) 101-11 .203(b)(10)

SF 506 (Rev 2-99)

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER
PHYSICAL EXAMINATION			

SAMPLE FORM

INITIAL IMPRESSION

SIGNATURE OF PHYSICIAN

NAME OF PHYSICIAN

Standard Form 506 (Rev. 2-99) BACK

Encl. (1) to CHAP 4, COMDTINST M6000.1B

MEDICAL RECORD		PROGRESS NOTES	
DATE			
	(Continue on reverse side)		
PATIENT'S IDENTIFICATION <small>(For typed or written entries give: name – last, first, middle; grade; rank; rate; hospital or medical facility)</small>		REGISTER NO.	WARD NO.

PROGRESS NOTES

MEDICAL RECORD

STANDARD FORM 509 (REV-7-91) EG

Prescribed by GSA/ICMR (41 CFR) 201-9.202-1

Designed using Perform Pro. WHS/DIOR, Jul94

Encl. (1) to CHAP 4, COMDTINST M6000.1B

ABBREVIATED MEDICAL RECORD			1. ADMISSION DATE (yyyymmdd)
2. CHIEF COMPLAINT, PERTINENT HISTORY, AND PERTINENT SYSTEM REVIEW			
3. PHYSICAL EXAMINATION <i>(Including pertinent positives and negatives)</i>			
4. IMPRESSION <i>(enter admission note with plan on progress notes)</i>			
5. ADMITTING OFFICER			
a. SIGNATURE			b. DATE SIGNED (YYYYMMDD)
6. DISCHARGE NOTE <i>(Brief hospital course, diagnoses, procedures, condition on discharge, pertinent discharge information (including medications, diet, activity limitations, follow-up instructions).)</i>			7. DISCHARGE DATE (YYYYMMDD)
8. DISCHARGE OFFICER			
a. NAME <i>(Last, First, Middle Initial)</i>	b. GRADE	c. TITLE	d. SIGNATURE
9. PATIENT IDENTIFICATION <i>(For typed or written entries: Name (last, first, middle), grade, SSN, date of birth, hospital or medical facility, ward number, and register number)</i>			10. OUTPATIENT/HEALTH RECORD MAINTAINED AT:
			11. COPY PLACED IN OUTPATIENT RECORD (x WHEN DONE)

DD FORM 2770, APR 1998 (EG) Replaces SF 509

HISTORY AND REPORT OF OMSEP EXAMINATION

PART 1 (This form is subject to the Privacy Act Statement of 1974)			
1. LAST Name, First Name, Middle Initial:		2. Grade/Rate/Rank:	3. SSN:
4. Date of Exam:		5. Home Address (apt#, Street#, street name, city, state, zip):	
6. Work/duty phone:		7. Unit Name and location (city & state):	
8. Home phone:		9. Unit OPFAC#:	10. Unit Zip Code:
11. Date of Birth & Age:	12. Sex (M or F):	13. Race or Ethnicity:	14. Occupation or usual duties (describe):
15. Examining facility name & location (City & State):			
16. Purpose of Examination: <div style="display: flex; justify-content: space-around;"> <input type="checkbox"/> Initial/Baseline <input type="checkbox"/> Exit/Separation </div>			17. How many years have you worked in this occupation?

Section I. OCCUPATIONAL HISTORY (patient must complete)

18. Are you exposed to any of the following hazards in your present job, Yes or No?

<table border="1" style="width: 60px; height: 30px; margin: 0 auto;"> <tr><td>Y</td><td>N</td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </table>	Y	N							Entry into closed spaces (tanks, voids) Vibration (jackhammer) Chemical (liquid, vapor, gas)	<table border="1" style="width: 60px; height: 30px; margin: 0 auto;"> <tr><td>Y</td><td>N</td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </table>	Y	N							Extreme cold/heat Metals (Lead fumes, other) Dust (sawdust, asbestos dust fibers)	<table border="1" style="width: 60px; height: 30px; margin: 0 auto;"> <tr><td>Y</td><td>N</td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </table>	Y	N							Bodily fluids, or infectious agents Mental or emotional stress
Y	N																												
Y	N																												
Y	N																												

19. Do you wear any of the following on your present job, Yes or No?

<table border="1" style="width: 60px; height: 30px; margin: 0 auto;"> <tr><td>Y</td><td>N</td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </table>	Y	N							Earplugs or muffs Dust mask Half-face respirator	<table border="1" style="width: 60px; height: 30px; margin: 0 auto;"> <tr><td>Y</td><td>N</td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </table>	Y	N							Full-face respirator Air-line respirator Safety glasses	<table border="1" style="width: 60px; height: 30px; margin: 0 auto;"> <tr><td>Y</td><td>N</td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </table>	Y	N							Welding face-mask Rubber gloves Protective body suit	<table border="1" style="width: 60px; height: 30px; margin: 0 auto;"> <tr><td>Y</td><td>N</td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </table>	Y	N							Other, list below in item 25.
Y	N																																						
Y	N																																						
Y	N																																						
Y	N																																						

20. Have you had any difficulty wearing your protective clothing or equipment? (If you don't need to wear any, answer "no")

21. Have you had any work-related illness or injury?

22. Have you been limited in your work for health reasons?

23. Have you left or changed jobs due to health reasons?

24. Do you have hobbies or outside activities, which would expose you to any of the hazards listed in 18, above? If yes explain.

25. If you marked "Yes" to any questions from items 19-24, explain in this section.

Section II. FAMILY HISTORY (patient must complete)

26. Have any blood relatives (mother, father, brother, sister, grandparents, aunts, uncles, children) had any of the following problems?

<table border="1" style="width: 60px; height: 30px; margin: 0 auto;"> <tr><td>Y</td><td>N</td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </table>	Y	N													Anemia, blood disease, or bleeding tendency Asthma, hayfever, allergies Birth defects or multiple miscarriages Cancer, leukemia, or other malignancy Diabetes Hearing problem, deafness	<table border="1" style="width: 60px; height: 30px; margin: 0 auto;"> <tr><td>Y</td><td>N</td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </table>	Y	N													Eye trouble or blindness Epilepsy, fits, or convulsions High blood pressure, stroke Kidney trouble (stones or kidney failure) Lung troubles cystic fibrosis, bronchitis, emphysema Other disease or family condition, if so list:
Y	N																														
Y	N																														

HISTORY AND REPORT OF OMSEP EXAMINATION

PART 1, (con't)		Section III. SOCIAL HISTORY <i>(patient must complete)</i>												
<p>27. Cigarettes/pipe/cigar smoking history.</p> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>Do you smoke cigarettes/cigars or a pipe now?</p> <p>If NO: Did you ever smoke cigarettes/pipes or cigars?</p> <p>If you smoked before, when did you stop?</p> <p>How many years have you smoked?</p> <p>How many cigarettes/cigars or pouches per week?</p> <p>If YES: How many years have you smoked?</p> <p>How many cigarettes/cigars or pouches per week?</p> </div> <div style="width: 50%;"> <table border="1" style="margin-left: auto; margin-right: auto;"> <tr> <th style="width: 50px;">Y</th> <th style="width: 50px;">N</th> </tr> <tr><td style="height: 20px;"></td><td style="height: 20px;"></td></tr> <tr><td style="height: 20px;"></td><td style="height: 20px;"></td></tr> <tr><td style="height: 20px;"></td><td style="height: 20px;"></td></tr> <tr><td style="height: 20px;"></td><td style="height: 20px;"></td></tr> <tr><td style="height: 20px;"></td><td style="height: 20px;"></td></tr> <tr><td style="height: 20px;"></td><td style="height: 20px;"></td></tr> </table> </div> </div>	Y	N												
Y	N													

HISTORY AND REPORT OF OMSEP EXAMINATION

PART 1, (con't)

OCCUPATIONAL EXPOSURE HISTORY

INSTRUCTIONS:

Please complete the following history beginning with present job or military assignment.
Additional copies of this sheet may be added if necessary.

34. List all known hazardous exposures:

[illegible]

All information provided will be handled in accordance with the Privacy Act requirements, and will not be otherwise disclosed.

I hereby certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge.

Signature of Patient:

Date:

HISTORY AND REPORT OF OMSEP EXAMINATION

PART 2

MEDICAL OFFICER'S SECTION

1. LAST Name, First Name, Middle Initial <i>(of patient)</i> :	2. Grade/Rate/Rank <i>(of patient)</i> :	3. SSN <i>(of patient)</i> :	4. Date of Exam:
--	--	------------------------------	------------------

5. Examining facility or examiner and address:	6. Facility phone #: ()
--	-------------------------------

7. Surveillance protocols followed *(check all that apply)*:

<input type="checkbox"/> Asbestos	<input type="checkbox"/> Chromium compounds	<input type="checkbox"/> Lead	<input type="checkbox"/> Respiratory sensitizers	<input type="checkbox"/> Solvents
<input type="checkbox"/> Alcohol or drug abuse	<input type="checkbox"/> Nutrition (low-fat/salt)	<input type="checkbox"/> Stress reduction	<input type="checkbox"/> Breast / testicular self-exam	<input type="checkbox"/> HCP
<input type="checkbox"/> Benzene	<input type="checkbox"/> Pesticides	<input type="checkbox"/> Resp wear	<input type="checkbox"/> Haz-Waste	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Unspecified				

8. List only occupational-related diagnoses by ICD code number and name: *(If no exact corresponding ICD code is available, use the closest code to the related diagnosis.)*

ICD Code	Diagnosis	ICD Code	Diagnosis

9. Respirator wear.

This examinee is ☐ medically approved for respirator wear. *(Comment on any restrictions or limitations.)*
☐ Is not approved for respirator wear.

10. CONCLUSIONS:

This examinee ☐ does have medical conditions which limit his/her performance of duties *(Specify any limitations.)*
☐ Does not have any conditions which limit his/her performance of duties.

11. Next OMSEP examination should be in: 12 months Other:

12. Examinee was informed about the results of this examination _____ (date).

13. Recommendations:

Printed or typed name/rank and degree of examining medical officer.	Signature of examining medical officer.	Date:
---	---	-------

PERIODIC HISTORY AND REPORT OF OMSEP EXAMINATION

1. LAST Name, First Name, Middle Initial:	2. Grade/Rate/Rank:	3. SSN:	4. Date of Exam:
5. Home Address (apt#, Street#, street name, city, state, zip):	6. Work/duty phone:	7. Unit Name and location (city & state):	
	8. Home phone:	9. Unit OPFAC#:	10. Unit Zip Code:
11. Examining facility name & location (City & State):	12. Date of Last OMSEP Exam:	13. Present Exposure Protocols:	
Review each section of the last CG 5447 (History and Report of OMSEP Examination). If there has been any changes to any section please list the item and how it has changed.			
Section I. OCCUPATIONAL HISTORY			
COMMENTS:			<input type="checkbox"/> No Change
Section II. FAMILY HISTORY			
COMMENTS:			<input type="checkbox"/> No Change
Section III. SOCIAL HISTORY			
COMMENTS:			<input type="checkbox"/> No change
Section IV. PERSONAL HEALTH HISTORY			
COMMENTS:			<input type="checkbox"/> No Change
OCCUPATIONAL EXPOSURE			
COMMENTS:			<input type="checkbox"/> No Change
HEALTH CARE PROVIDER REVIEW			
RECOMMENDATIONS:		Lab Results Reviewed	Initial <div style="border: 1px solid black; width: 40px; height: 20px; margin: 2px;"></div> <div style="border: 1px solid black; width: 40px; height: 20px; margin: 2px;"></div>
		X-ray Results Reviewed	
		Other:	
Health Care Provider, (<i>print or type</i>):	Health Care Provider Signature:	Date:	

AUTHORIZATION FOR DISCLOSURE OF MEDICAL OR DENTAL INFORMATION**PRIVACY ACT STATEMENT**

In accordance with the Privacy Act of 1974 (Public Law 93-579), the notice informs you of the purpose of the form and how it will be used. Please read it carefully.

AUTHORITY: Public Law 104-191; E.O. 9397 (SSAN); DoD 6025.18-R.

PRINCIPAL PURPOSE(S): This form is to provide the Military Treatment Facility/Dental Treatment Facility/TRICARE Health Plan with a means to request the use and/or disclosure of an individual's protected health information.

ROUTINE USE(S): To any third party or the individual upon authorization for the disclosure from the individual for: personal use; insurance; continued medical care; school; legal; retirement/separation; or other reasons.

DISCLOSURE: Voluntary. Failure to sign the authorization form will result in the non-release of the protected health information.

This form will not be used for the authorization to disclose alcohol or drug abuse patient information from medical records or for authorization to disclose information from records of an alcohol or drug abuse treatment program. In addition, any use as an authorization to use or disclose psychotherapy notes may not be combined with another authorization except one to use or disclose psychotherapy notes.

SECTION I - PATIENT DATA

1. NAME (Last, First, Middle Initial)	2. DATE OF BIRTH (YYYYMMDD)	3. SOCIAL SECURITY NUMBER
4. PERIOD OF TREATMENT: FROM - TO (YYYYMMDD)	5. TYPE OF TREATMENT (X one) <input type="checkbox"/> OUTPATIENT <input type="checkbox"/> INPATIENT <input type="checkbox"/> BOTH	

SECTION II - DISCLOSURE

6. I AUTHORIZE _____ TO RELEASE MY PATIENT INFORMATION TO: (Name of Facility/TRICARE Health Plan)									
a. NAME OF PHYSICIAN, FACILITY, OR TRICARE HEALTH PLAN	b. ADDRESS (Street, City, State and ZIP Code)								
c. TELEPHONE (Include Area Code)	d. FAX (Include Area Code)								
7. REASON FOR REQUEST/USE OF MEDICAL INFORMATION (X as applicable) <table border="0"><tr><td><input type="checkbox"/> PERSONAL USE</td><td><input type="checkbox"/> CONTINUED MEDICAL CARE</td><td><input type="checkbox"/> SCHOOL</td><td><input type="checkbox"/> OTHER (Specify)</td></tr><tr><td><input type="checkbox"/> INSURANCE</td><td><input type="checkbox"/> RETIREMENT/SEPARATION</td><td><input type="checkbox"/> LEGAL</td><td></td></tr></table>		<input type="checkbox"/> PERSONAL USE	<input type="checkbox"/> CONTINUED MEDICAL CARE	<input type="checkbox"/> SCHOOL	<input type="checkbox"/> OTHER (Specify)	<input type="checkbox"/> INSURANCE	<input type="checkbox"/> RETIREMENT/SEPARATION	<input type="checkbox"/> LEGAL	
<input type="checkbox"/> PERSONAL USE	<input type="checkbox"/> CONTINUED MEDICAL CARE	<input type="checkbox"/> SCHOOL	<input type="checkbox"/> OTHER (Specify)						
<input type="checkbox"/> INSURANCE	<input type="checkbox"/> RETIREMENT/SEPARATION	<input type="checkbox"/> LEGAL							

8. INFORMATION TO BE RELEASED

9. AUTHORIZATION START DATE (YYYYMMDD)	10. AUTHORIZATION EXPIRATION <input type="checkbox"/> DATE (YYYYMMDD) <input type="checkbox"/> ACTION COMPLETED
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SECTION III - RELEASE AUTHORIZATION

I understand that:

- I have the right to revoke this authorization at any time. My revocation must be in writing and provided to the facility where my medical records are kept or to the TMA Privacy Officer if this is an authorization for information possessed by the TRICARE Health Plan rather than an MTF or DTF. I am aware that if I later revoke this authorization, the person(s) I herein name will have used and/or disclosed my protected information on the basis of this authorization.
 - If I authorize my protected health information to be disclosed to someone who is not required to comply with federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.
 - I have a right to inspect and receive a copy of my own protected health information to be used or disclosed, in accordance with the requirements of the federal privacy protection regulations found in the Privacy Act and 45 CFR §164.524.
 - The Military Health System (which includes the TRICARE Health Plan) may not condition treatment in MTFs/DTFs, payment by the TRICARE Health Plan, enrollment in the TRICARE Health Plan or eligibility for TRICARE Health Plan benefits on failure to obtain this authorization.
- I request and authorize the named provider/treatment facility/TRICARE Health Plan to release the information described above to the named individual/organization indicated.

11. SIGNATURE OF PATIENT/PARENT/LEGAL REPRESENTATIVE	12. RELATIONSHIP TO PATIENT (If applicable)	13. DATE (YYYYMMDD)
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SECTION IV - FOR STAFF USE ONLY (To be completed only upon receipt of written revocation)

14. X IF APPLICABLE: <input type="checkbox"/> AUTHORIZATION REVOKED	15. REVOCATION COMPLETED BY	16. DATE (YYYYMMDD)
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17. IMPRINT OF PATIENT IDENTIFICATION PLATE WHEN AVAILABLE	SPONSOR NAME: SPONSOR RANK: FMP/SPONSOR SSN: BRANCH OF SERVICE: PHONE NUMBER:
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REQUEST TO RESTRICT MEDICAL OR DENTAL INFORMATION**PRIVACY ACT STATEMENT**

In accordance with the Privacy Act of 1974 (Public Law 93-579), the notice informs you of the purpose of the form and how it will be used. Please read it carefully.

AUTHORITY: Public Law 104-191; E.O. 9397 (SSAN); DoD 6025.18-R.

PRINCIPAL PURPOSE(S): This form is to provide the patient with a means to request a restriction on the use and disclosure of his/her protected health information.

ROUTINE USE(S): To other entities or physicians for: judicial and administrative purposes; health oversight; research; law enforcement; public health; to avert a serious threat to health and safety; organ, eye, or tissue donation; decedents; Worker's Compensation; victims of abuse, neglect, or domestic violence; specialized government functions; and required by law.

DISCLOSURE: Voluntary. Failure to sign the authorization form may result in a release of the protected health information.

This form will not be used to request restrictions on the use or disclosure of any alcohol or drug abuse patient information from medical records of an alcohol or drug abuse treatment program.

SECTION I - PATIENT DATA

1. NAME (Last, First, Middle Initial)	2. DATE OF BIRTH (YYYYMMDD)	3. SOCIAL SECURITY/IDENTIFICATION NUMBER
4. PERIOD OF TREATMENT: FROM - TO (YYYYMMDD)	5. TYPE OF TREATMENT (X one) <input type="checkbox"/> OUTPATIENT <input type="checkbox"/> INPATIENT <input type="checkbox"/> BOTH	

SECTION II - RESTRICTIONS

6. REQUEST (RESTRICTION) IS DIRECTED TO THE TRICARE HEALTH PLAN OR THE FOLLOWING PHYSICIAN/FACILITY:		
a. NAME OF PHYSICIAN, FACILITY, OR TRICARE HEALTH PLAN		b. ADDRESS (Street, City, State and ZIP Code)
c. TELEPHONE (Include Area Code)	d. FAX (Include Area Code)	7. PURPOSE OF RESTRICTION (Optional)
8. REQUESTED DATES OF RESTRICTION (YYYYMMDD) a. START: b. END:		
9. SPECIFY MEDICAL INFORMATION TO BE RESTRICTED (Use back for additional space)		

SECTION III - PLEASE READ AND SIGN BELOW

I understand that:

1. The Military Treatment Facility (MTF)/Dental Treatment Facility (DTF)/TRICARE Health Plan is not required to approve this request for restriction.
2. If approved by an MTF/DTF, this restriction only applies to the MTF/DTF that granted approval. It is not transferable to other providers, MTF's or DTF's.
3. If approved, the MTF/DTF/TRICARE Health Plan is not required to abide by this restriction if the health information is needed to provide emergency treatment or services.
4. If approved, this restriction does not prevent me from having access to my own health information or to an accounting of how my health information has been used.
5. If this request for restriction is approved, the MTF/DTF/TRICARE Health Plan still has the right to use or disclose my health information under the following circumstances: judicial and administrative purposes; health oversight; research; law enforcement; public health; to avert a serious threat to health and safety; organ, eye, or tissue donation; decedents; Worker's Compensation; victims of abuse, neglect, or domestic violence; specialized government functions; and required by law.
6. Once approved, this restriction can be terminated under the following circumstances:
 - a. If I request the termination in writing.
 - b. If I request the termination orally and it is documented by the MTF/DTF.
 - c. If the MTF/DTF/TRICARE Health Plan informs me that it has decided to terminate the restriction. In this situation, the termination only applies to the health information created or received after the termination is in effect.

10. SIGNATURE OF PATIENT/GUARDIAN	11. RELATIONSHIP TO PATIENT (If applicable)	12. DATE (YYYYMMDD)
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SECTION IV - FOR PROVIDER/FACILITY USE ONLY

13. X AS APPLICABLE: <input type="checkbox"/> REQUEST APPROVED <input type="checkbox"/> REQUEST IS DISAPPROVED <input type="checkbox"/> RESPONSE ATTACHED	14. SIGNATURE OF APPROVING OFFICIAL
15. IMPRINT OF PATIENT IDENTIFICATION PLATE WHEN AVAILABLE	SPONSOR NAME: FMP/SPONSOR SSN: SPONSOR RANK: BRANCH OF SERVICE: PHONE NUMBER:

9. SPECIFY MEDICAL INFORMATION TO BE RESTRICTED *(Continued)*